Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Dec 10, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:
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Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. However at the time, his insurance carrier was denying liability for his neck.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expire in March 2021. Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied and are currently being appealed. He has never trialed chiropractic therapy before, but he prefers to wait and see if acupuncture will be appeal approved prior to proceeding with chiro. He has also trialed massage therapy in the past although this actually aggrevated his symptoms more.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today. He also inquires about trialing Flector patch for topical relief of his symptoms.

We have received his QME report from Dr. Stoller. This is reviewed below.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who imformed him this would improve with time.

Medical History:
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PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.

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5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
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PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Neck
Please submit as a change in material facts and attach Dr. Stoller report to RFA (uploaded to IMS on DOS 12/10/20).

This is a formal request for authorization of the medications within the "prescriptions" section of

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this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

1 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

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Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We do not have this report for review.

-Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied and is currently being appealed. We may consider trialing chiropractic therapy at his next visit should acupuncture remain denied.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19 and they expire in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left

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paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

-We reviewed the QME supplemental from Dr. Stoller. Per this report, he agrees that the patient's neck should be treated on an industrial basis and recommended that he see a specialist. In light of this finding, we will resubmit for the consult today.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. Patient states that he was recently let go from his employer.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. We will also trial him on Flector patch for topical relief. He has not trialed this yet, therefore no previous benefit can be documented. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

Follow up in 4-6 weeks.

WORK STATUS:
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WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. To expedite the process in which we may provide the appropriate treatment for our patient, please

consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's

decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Specialist Consults: The following has been recommended by the MTUS/ACOEM guidelines regarding Specialist Consults:

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Appropriate and Timely Specialist Referral:
Physicians should recognize when recovery and rehabilitation progress has stalled (use of guidelines and disability durations may assist in this process) or their capabilities in managing the affected worker have been exceeded, and seek appropriate specialist referral. (See critical nature of time in recovery from work disability discussed in the Iatrogenicity section.) This is related to avoidance of overtreatment (particularly continuation of ineffective therapy as previously discussed. Physicians may be hesitant to refer for a variety of reasons:

- Reluctance to accept their own limitations;
- Fear of 'losing' the patient to a specialist;
- Fear of negative reaction from the employer or insurer;
- Delays in the authorization process; and
- Lack of availability of healthcare providers willing to see workers, or specialist access in certain geographic areas or markets (including physical presence or willingness to treat workers' compensation cases).

As noted previously in the context of workplace depression, it is extremely helpful for physicians to develop ongoing referral networks, and to know the characteristics of referral sources whenever possible. Occupational medical providers should ensure that referrals are made to specialists whose approaches and quality of care are known and acceptable.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
6 Week(s)

CC:
Kweller, Esq., Zachary : 12/14/2020
Castro, Mario : 12/14/2020
Kweller, Esq., Zachary : 12/16/2020
Castro, Mario : 12/16/2020
UR, Chubb : 12/16/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 12/14/2020

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Pain & Rehabilitative
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WALNUT CREEK
ROHNERT PARK
MANTECA

SUPPLEMENTAL REPORT

RE: SHOCKLEY, JONATHAN
CL#: 040519008736
DOB: 09/27/1978
DOI: 02/15/2019
DATE OF SERVICE: 12/03/2020

INTRODUCTION

This is a supplemental report to address **6 sessions of acupuncture**, which was requested on **11/06/20**.

I spent a total of 66 minutes of non-face-to-face prolonged service that relates to (face-to-face) care that has or will occur and ongoing patient management. Total time spent provided included the review of records from other physicians, review of diagnostic studies, and correspondence from CorVel Corporation dated 11/20/2020 for **6 sessions of acupuncture.**

Therefore, this report will be billed as 99358 x 1 unit. Please note that this 99358 service is prolonged to an initial service on 11/06/20.

This billing is to reflect extraordinary time spent in patient care that was not spent in direct face-to-face time. This includes time spent in other ongoing care management work as described in the Federal Register, Vol 81 No 220, and adopted by the Acting Administrative Director of the Division of Workers' Compensation, GEORGE P. PARISOTTO, on January 17, 2017.

Your denial letter dated 11/20/2020 states, "In this case, the patient has been authorized for 42 sessions of acupuncture which significantly exceeds guideline recommendations of a maximum of 12 sessions. Despite a substantial amount of acupuncture, the records do not establish associated significant sustained pain relief or any quantifiable functional improvements. The patient remains off work. IMR recently determined that additional acupuncture is not medically necessary and appropriate. Therefore, my recommendation is to NON-CERTIFY the request for Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb".

Please allow me to address this denial.

HISTORY OF PRESENT ILLNESS

The patient is a 42-year-old right-handed man who was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left. His left developed pain problems. He initially had pain around the wrist

area. The pain has gradually traveled up the arm towards the neck. He also has occasional hand pain.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 that shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI; the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

An EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side. With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy. We do not have this report for review.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. Previously, the patient had been attending acupuncture therapy with benefit.

At the present time, patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient reports that a few months back he took Gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. Due to the fatigue, the patient he had some bloodwork done that showed elevated TSH. He attributes this elevation in TSH is due to his use of Gabapentin and inquiries about having this level repeated.

We requested **6 sessions of acupuncture**; however, our request has been denied due to the reasons mentioned above.

PREVIOUS PHYSICAL EXAMINATION

Spine: There is TTP in the cervical paraspinal muscles. There was discomfort with lateral tilt of the cervical spine. Cervical spine lateral tilt to the left is 25% and lateral tilt to the right is 15%. Palpation of the volar aspect of the wrists were tender bilaterally. He has reduced 1+ biceps reflex and absent triceps and brachioradialis reflexes.

DIAGNOSTIC STUDIES

EMG was completed on 2/10/20 with Dr. Neeti Bathia,

Impression: Demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

MRI of the cervical spine dated 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6.

DISCUSSION

Regarding the denial of **6 sessions of acupuncture**, the UR physician felt that, "In this case, the patient has been authorized for 42 sessions of acupuncture which significantly exceeds guideline recommendations of a maximum of 12 sessions. Despite a substantial amount of acupuncture, the records do not establish associated significant sustained pain relief or any quantifiable functional improvements. The patient remains off work. IMR recently determined that additional acupuncture is not medically necessary and appropriate. Therefore, my recommendation is to NON-CERTIFY the request for Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb".

Please note that the patient had excellent benefits from prior sessions of acupuncture. He reported a reduction in his pain complaints from a 4-5/10 to a 2-3/10 on VAS, constituting a 10-20% reduction in his pain complaints for 2-3 days. He was able to do his ADLs better and there was overall improvement in his symptoms with acupuncture therapy.

However, it is very common for chronic pain patients to have acute flare-ups. They do have good days and bad days where their pain waxes and wanes as in this case. At the present time, patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity. On examination, there is TTP in the cervical paraspinal muscles. There was discomfort with lateral tilt of the cervical spine. Cervical spine lateral tilt to the left is 25% and lateral tilt to the right is 15%. Palpation of the volar aspect of the wrists were tender bilaterally. He has reduced 1+ biceps reflex and absent triceps and brachioradialis reflexes. Thus, indicating the presence of pain, inflammatory pathology and functional limitations for which Acupuncture is indicated by the guidelines.

This patent saw Dr. Gordon on 07/22/20 who does not recommend a surgical intervention. Massage therapy made his pain worse. He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. Patient reports that a few months back he took Gabapentin to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. Due to the fatigue, the patient had some bloodwork done that showed elevated TSH. He attributes this elevation in TSH is due to his use of Gabapentin and he discontinued its use. He also has a medical history of epilepsy. Given all these, we would like to minimize his reliance on oral pain medications by identifying alternative treatment options like acupuncture for his pain. He reported good benefit from prior session of acupuncture as documented above.

Please note that the new ACOEM guidelines do recommend Acupuncture as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to

be achieved. Also, there are studies, which support immediate Analgesic Effect of Acupuncture for Pain. We have documented an article below under supporting guidelines.

Please note this patient did have a PQME with Dr. Stroller on 1/23/20. Dr. Stroller did recommend that the patient have Acupuncture sessions under future medical care.
Acupuncture has the advantage of not using medications, which can be costly and have significant adverse side effects. Acupuncture as a non-medication conservative treatment has the potential to successfully reduce patient's pain after long-term follow-up, reduce the intake of costly pain medications and improve patients' overall function. We do believe that with this conservative treatment, we may also avoid invasive procedures for this patient. The goals of acupuncture treatment would be reduction in his pain, increase the ROM, improve his functional capacities, reduce his medication requirements, and allow him to better tolerate his ADLs. These acupuncture sessions will be done in conjunction with his home exercise program to obtain maximal benefits in terms of pain relief and function as well as to minimize the use of oral pain medications given his medical history. We will monitor his progress after each session. Therefore, our request for 6 sessions of Acupuncture for the neck, bilateral hands, wrists, and forearms should be authorized. The treatment is consistent with the guidelines.

SUPPORTING GUIDELINES:
Following has been recommended regarding **Acupuncture** in the ACOEM guidelines:
Acupuncture for Chronic Persistent Pain
Recommended.

Acupuncture is recommended to treat chronic persistent pain.
Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain, especially torso pain. Patients should have had NSAIDs and/or acetaminophen, stretching and aerobic exercise instituted and have insufficient results. Acupuncture may be considered as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to be achieved. Consideration is for time-limited use in patients with chronic persistent pain without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is only recommended to assist in increasing functional activity levels more rapidly and the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.

Benefits: Potential to improve pain control and advance functional exercises and conditioning.

Harms: Negligible in experienced hands. Pneumothoraces have occurred and puncture of other internal organs has occurred.

Frequency/Dose/Duration: Evidence does not support specific Chinese meridian approaches, as needling the affected area appears sufficient. Patterns used in quality studies ranging from weekly for a

month to 20 appointments over 6 months. However, the norm is generally no more than 8 to 12 sessions. An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures and would justify an additional 6 sessions, for a total of 12 sessions.

Indications for Discontinuation: Lack of improvement, lack of compliance with exercises, lack of incremental functional gain at the end of a treatment course, intolerance.

Rationale: There are multiple quality trials of acupuncture for treatment of many disorders, especially of low back pain (see Low Back Disorders Guideline). There are no quality trials evaluating acupuncture for treatment of non-specific chronic persistent pain. (One small study found no differences between sham and classic Chinese acupuncture.[243] There are quality studies evaluating acupuncture for the treatment of chronic pain including chronic neck pain, LBP, osteoarthrosis (especially of the knee), lateral epicondylitis, adhesive capsulitis of the shoulder, and headaches.[133, 244] Many different study designs have been used. These include comparisons with shams that insert needles in non-traditional locations, minimal acupuncture with superficial needling, shams that do not insert needles, and comparisons with non-acupuncture treatments. Some studies have combined the acupuncture with electrical currents, and others have applied electrical currents to acupuncture sites. There is no clear benefit of electroacupuncture over needling. There remain some questions about efficacy of acupuncture,[245, 246] with concerns about biases, e.g., attention and expectation bias, in these study designs. Some, but not all studies, suggest persistence of meaningful benefits beyond the duration of treatment.

The majority of studies have demonstrated that there is no benefit of traditional Chinese acupuncture over other types of acupuncture. The evidence to address that question prominently includes all of the highest quality studies.[247-249] One study that evaluated acupuncture in trigger points found benefit from needling over either traditional acupuncture or acupuncture applied to other sites,[250] but that study has not been replicated. There is similarly a suggestion that superficial needling may be as efficacious as deep needling of muscles,[251] but not all studies have found that result.[252] Thus, aside from having identified that there does not appear to be a benefit from traditional acupuncture over other forms of acupuncture, other aspects of needling need further study. Evidence of benefits from acupuncture is strongest for LBP (see Low Back Disorders). However, there is consistent evidence of benefit for chronic neck pain.[250, 253-255] There are few quality studies evaluating the utility of acupuncture for treatment of tender and trigger points and they tend to have significant design flaws which limit the strength of conclusions. Efficacy of acupuncture for this indication is suggested by the highest quality study.[250]
Acupuncture when performed by experienced professionals is minimally invasive, has minimal adverse effects, and is moderately costly. Despite significant reservations regarding its true mechanism of action, a limited course of acupuncture may be recommended for treatment of certain specific disorders[244, 256-265] (see other guidelines, including Elbow Disorders and Cervical and Thoracic Spine Disorders). Acupuncture is minimally invasive, has low adverse effects, is moderately costly, appears to have some evidence of efficacy, and is recommended.

Evidence: There are no quality studies evaluating acupuncture for the treatment of chronic persistent pain.

1. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5676441/

This is the first systematic review and meta-analysis of RCTs on the immediate effects of acupuncture for the treatment of disease-related pain. We included a total of 13 studies in our review. The results showed statistically significant differences between the efficacy of real acupuncture and those of sham controls for all types of pain included in this review. The SMDs between real acupuncture and control sham acupuncture were lower than those between real acupuncture and a no-acupuncture control. In addition, acupuncture appeared to be more effective than analgesic injection (at intragluteal site with analgesic or local infiltration with anesthetic) in reducing pain. The meta-analytic effect sizes were not similar across pain conditions. There was no evidence of any significant harm caused by acupuncture in any of the RCTs. However, it should be stressed that this lack of evidence is based on the results of a few small trials with a high risk of bias. Therefore, a careful interpretation is warranted before arriving at a positive conclusion.

Compared with the assessment of the cumulative effects of acupuncture, the determination of the immediate effects could be relatively easy; that is, it is not necessary to consider the treatment endpoint or follow-up duration. Acupuncture also has a very low drop-out rate. For the systematic review and meta-analysis of the efficacy of acupuncture, various factors could affect the outcomes in the evaluation of the cumulative effects of acupuncture, including the total number of treatment sessions, treatment period, and variation in the end points, such as those of pain and function measurements at different times. Because of the exclusion or minimization of these variable factors, the evaluation of the immediate effect may closely reflect the actual analgesic effects of acupuncture stimulation.

Primary analgesic agents, such as morphine, can be used for the management of both acute and chronic pain. The peak effect of morphine is at around 20 min when administered intravenously and at 60 min when administered orally, while the duration of its effect is between 3 and 7 h [52, 53]. The results of our systematic review and meta-analysis indicate that acupuncture shows an immediate analgesic effect as the treatment of chronic pain. In general, the duration of onset of the effect of acupuncture is 15–30 min [15, 54]. The duration of the analgesic effect following a single session of acupuncture is about 3 days, although this duration is not consistent [55]. Therefore, the immediate effect of acupuncture may have clinical significance as an alternation for analgesic medication or as a reasonable method for pain treatment. Moreover, the success of acupuncture as a treatment of pain is often gauged by the number of clients retained in pain management or treatment facilities. The apparent benefits of the immediate analgesic effect of acupuncture may entice patients to receive long-term acupuncture treatment willingly or open to other forms of acupuncture options. Therefore, the immediate success of acupuncture treatment should not be overestimated. In present study, we did not find a greater immediate pain relief effect of acupuncture for acute pain compared with the sham acupuncture (P = 0.46). However, our sensitivity analysis showed that real acupuncture was more effective than the sham acupuncture in reducing acute pain immediately, if excluding the study by Zhang et al. [42]. This might be explained by some variable factors, such as the types of sham acupuncture, control procedures, and outcome measures. Further rigorous studies with standardized methodologies are required to test the efficacy of acupuncture for the treatment of acute pain.

The design of a control group is a continuing challenge for clinical trials of acupuncture. Many clinical trials were unable to detect statistically significant differences in the treatment efficacies between their acupuncture treatment and control groups in terms of any of the outcome measurements [56–58]; the authors of these trials concluded that acupuncture was no more effective than any sham interventions, for example, skin-touch sham (nonpenetrating) and skin-penetration sham in reducing pain. Based on the results of this systemic review and meta-analysis study, we found real acupuncture treatment has statistically significantly greater immediate pain relief than nonpenetrating sham acupuncture (SMD, −0.70; 95% CI, −1.21 to −0.20; 4 RCTs), but not these of penetrating sham acupuncture (SMD, −0.46; 95% CI, −1.11 to 0.18; 5 RCTs). Interestingly, when we excluded the study by Zhang et al. [42], we found real acupuncture was more effective than the sham acupuncture in relieving pain immediately after acupuncture treatment, which indicates some sham acupuncture treatment is not inactive.

Our systematic review and meta-analysis study focuses on the immediate analgesic effect of acupuncture. This raises some interesting questions. The first question is whether the immediately analgesic effect following the first acupuncture treatment can be used as a predictor for the success of subsequent or long-term acupuncture treatment. Most clinical trials focused on analgesic effects after multiple acupuncture treatment. Few studies assessed analgesic effects after both immediate posttreatment and multiple acupuncture treatments. Therefore, further studies must be performed to clarify this issue. The second question is whether the immediate acupuncture analgesic effect and cumulative analgesic effects following repeated acupuncture treatments share common mechanisms. Thus far, there is no clear documentation in regard to the underlying mechanisms of these two analgesic effects. Based on the available data published, needle insertion of the local acupuncture points triggers the release of adenosine and changes of fibroblast organization at the loose connective tissue layer [59–61]. The cumulative analgesic effects following repeated acupuncture treatments on the brain differ from the immediate analgesic effect after one acupuncture treatment. The immediate analgesic effect of acupuncture was a result of an extensive brain activation at selective pain-related regions [62]. However, the cumulative analgesic effects of acupuncture indicated bimodal habituation—a positive brain response appeared at the beginning of acupuncture stimulation, which then declined and became negative towards the final stages [28]. From neurohormonal prospective, a single acupuncture treatment can facilitate the release of opioid peptides [19]. Repeated administration of electroacupuncture leads to the development of opioid tolerance [63, 64]. Therefore, although acupuncture has both immediate and cumulative analgesic effects following repeated treatments, underlying mechanisms may be different.

Our systematic review and meta-analysis study has several limitations. Only English and Chinese literatures were reviewed in present study and potential data from studies published in other languages might exist and were ignored, which decreased the credibility of the results in present study to some extent. We included RCTs evaluating various types of pain, including chronic neck pain, LBP, and knee pain. In fact, accumulated work has shown that acupuncture is beneficial in treatment of various pain syndromes. The effects of acupuncture on nonspecific pain may share the similar underlying mechanisms. In traditional Chinese medicine, disease-related pain results from stagnation of energy "Qi" flow within meridians. Pain is treated locally or distally via acupuncture points further along the meridian, drawing energy away from the pain. Recently, the neurophysiology of acupuncture has been investigated extensively. Local anesthesia at the needle-insertion sites completely blocks the immediate analgesic effect of acupuncture, indicating that these effects are dependent on intact neural conduction. The immediate analgesic effect on various types of pain may be involved in the nociceptive pathway, including descending noradrenergic and serotonergic pathways [65]. In our

meta-analysis, a high level of heterogeneity may be resulted from the baseline values, the acupuncture manipulation, acupuncture points selected, and the duration and frequency of treatment. Our review has a number of strengths. First, our search for relevant studies was extensive. Key Chinese databases were explored in addition to the English databases. Second, we assessed the differences in the immediate analgesic effect of acupuncture between real acupuncture and different types of controls. Third, the review only evaluated RCTs, which have study designs appropriate for the determination of the effects of intervention.

In conclusion, this review facilitates a better understanding of acupuncture stimulation and its immediate analgesic effect for disease-related pain. The results of our systematic review and meta-analysis suggest that evidence of the immediate analgesic effect of acupuncture is encouraging, but not convincing. Nevertheless, our review has yielded interesting and innovative findings and provided impetus to further investigations. Further rigorous, high-quality, randomized controlled trials comparing acupuncture with nontreatment and sham acupuncture without skin penetration are required to evaluate the immediate analgesic effect of acupuncture.

Kindly reconsider authorization for **6 sessions of acupuncture for the neck, bilateral hands, wrists, and forearms.** We hope we have clarified the medical necessity for our request and this is authorized soon. Please note that this patient meets the guidelines criteria for warranting treatment and we will continue to keep the insurance updated regarding this patient's progress.

Further delay of this patient's treatment would only serve to prolong his suffering and increase the overall cost to the California Workers' Compensation system through prolongation of the utilization review process.

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true."

"I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

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Supervising:

Babak J. Jamasbi, M.D., F.A.C.P.M.

Performing:

Thrisha Kashinath PA-C

Thrisha Kashinath, PA-C

Signed this 3rd day of December 2020 in Alameda County.

CC:

Mario Castro, Claim Adjuster
Fax (800) 664-1765

Zachary Kweller, Attorney at Law
Fax (866) 819-6169

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley 09/27/1978 Date 12/08/2020

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ APPEAL - 6 sessions of Acupunture for the Neck, Bilateral hands, wrist and forearm

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm , M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm ,
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region , G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

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DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

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January 23, 2020

PANEL QUALIFIED MEDICAL EVALUATION - ML-102

RE: SHOCKLEY, Jonathan
DOB: 09/27/1978
INSURANCE: Chubb Group Insurance Company
CLAIM #: 7173815490
DOI: 02/15/2019
EMPLOYER: CardioNet

Dear Concerned Parties:

Mr. Jonathan Shockley had an appointment for Remedy Medical Group at 01/23/20 on 490 Post Street, Suite 900, San Francisco, California 94102 from 1 p.m. to 2 p.m. I spent one hour face-to-face with the patient. Rosa Fesili assisted me with record review. A total of forty-five minutes were spent in record review. This will be billed as an ML-102.

HISTORY OF PRESENT ILLNESS:

Mr. Shockley is a right-handed EKG technician at CardioNet. His job is comprised of processing approximately thousand EKGs an hour, which involves about seven hours of day of sitting to work on the computer, extensive mouse clicking, and keyboarding. He has a history of hand and wrist pain in 2009 while he was teaching ballet. He saw a hand surgeon, Dr. Markison, who recalls that he has right-sided greater than left-sided tenosynovitis that resolved several weeks after its onset. He started working in June 2018 at CardioNet. He noticed initially that his right hand started hurting and he got a left-handed mouse in October 2018. He had no right hand improvement and then his left hand and forearm started hurting him. He got a pedal, so he could click with his foot in December 2018 and his foot started bothering him.

On 02/15/19, he had extreme pain in both hands and arms and reported it to his boss. He was sent to see Dr. Lang, who is a hand surgeon. The hand surgeon sent him to PT where they did an ultrasound and hot and cold therapy which did not help. He was not offered any injection or further therapies. He was made permanent and stationary and Dr. Jamasbi later saw him and did acupuncture, massage, and during the course of treatment of Dr. Jamasbi, he received some TENS therapy which he states caused a flare-up of his pain. He has not received TENS since that episode, but he reports that his pain on the right side still goes up into his right shoulder.

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CURRENT COMPLAINTS:

He reports bilateral arm aching and burning and bilateral neck aching. He states that his bilateral arm pain is constant and moderate in intensity and he has intermittent neck pain that is mild and he has arm numbness and tingling that is intermittent and mild. He also reports moderate loss of sexual functioning.

His neck pain ranges from 2 to 3 out of 10. His arm pain is currently between a 3 and a 4 out of 10. His pain is exacerbated by lifting, hand activity, writing, cleaning, and dressing. It is better with rest, acupuncture, and massage. Ibuprofen and diclofenac are also helpful in alleviating his pain. He has no problems with sitting, standing, or walking tolerance. Treatment for his current problem; He went to Golden Gate Hand Therapy for nine weeks twenty-five weeks ago. He had a 5% improvement. He had acupuncture with Andreas Schwerte for eight weeks, which improved his pain by 25%. He denies any problems with gait or loss of bladder or bowel control. The sports or activities he is unable to perform include ballet, chess teaching, house repairs, lifting heavy objects, cleaning, and/or cooking massage, sexual activities, and card playing.

His sleep is affected. It is hard to fall asleep when he has a flare of his pain. He gets six to seven hours of sleep a night. He has difficulty both falling asleep and staying asleep.

He states that a lot of activities are affected because he is unable to use his hands or his fingers.

His mood is affected. He has increased anxiety despair, which he is managing with medication.

His gastrointestinal system is not affected.

His functional limitations include not being able to write, use a computer or cell phone, difficulty with cooking, cleaning, lifting heavy objects, playing sports, house repairs and projects, teaching ballet or chess, firmly shaking hands. He cannot lift any more than 5 pounds.

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MEDICAL HISTORY:

1. Anxiety.

SURGICAL HISTORY:

1. Adenoidectomy.
2. LASIK surgery.
3. Sympathectomy.
4. Big toe bone spur removal.
5. Achilles tendon debridement.

SOCIAL HISTORY:

He is single. He does not consume any alcohol. He does not use any tobacco products.

FAMILY HISTORY:

Rheumatoid arthritis.

REVIEW OF SYSTEMS:

Fourteen-point review of systems is positive for the aforementioned problems, otherwise, negative.

OCCUPATIONAL HISTORY:

He worked as an EKG tech initially at BioTelemetry LifeWatch, started in June 2018. He was with this employer for a year. He was in the occupation for a year.

His previous employer was Pacific Chess Academy. He was with them for two years.

In the course of a normal workday, he states he was sitting for seven and a half hours. The demands that restrict him from regular duty are continuous computer work with mousing and keyboarding.

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He was satisfied with his job.

TREATING PROVIDERS:

1. Dr. Patrick Lang.
2. Dr. Babak Jamasbi.
3. Dr. Robert Markison.

CURRENT MEDICATIONS:

1. Advil, taking a total of 1600 mg a day.
2. Voltaren cream.
3. Aspirin 81 mg.

DRUG ALLERGIES:

He has no known drug allergies.

VALIDATED QUESTIONNAIRES:

1. PHQ-9 is 1/30, indicating no reactive depression.
2. Epworth Sleepiness Scale is 3, indicating no abnormal daytime somnolence.

QUESTIONS CONCERNING ACTIVITIES OF DAILY LIVING:

1. Self-care activities are uncomfortable and done slowly.
2. I can lift and carry heavy objects, but I get extra discomfort.
3. There has been no change in his ability to walk after the injury.
4. He states very heavy activity is the most strenuous level of activity he can do for at least two minutes.
5. He has no difficulty climbing a flight of stairs.
6. He can sit without any time limitation.
7. He can stand or walk between one to two hours at a time.
8. He has some difficulty with reaching and grasping for something off of a shelf at chest level.

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9. He has some difficulty reaching and grasping for something off of a shelf overhead.
10. He can push or pull heavy objects.
11. He has a lot of difficulty with griping, grasping, holding, and manipulating objects with his hands.
12. He has a lot of difficulty with repetitive motions such as typing on a computer.
13. He has a lot of difficulty with forceful activities with his arm and hands.
14. He has no difficulty with kneeling, bending, and squatting.
15. His sleep is moderately disturbed because of his injury.
16. There has been a moderate change in his sexual function due to his injury.
17. His pain is moderate at the moment.
18. His pain is moderate most of the time.
19. His pain and injury interfere with his ability to travel some of the time.
20. Most of the time, his pain and injury interfere with his ability to do daily chores.
21. Some or little of the time, his pain and injury interfere with his ability to engage in social activities.
22. A lot or most of the time, his pain and injury interfere with his ability to engage in recreational activities.
23. Some of the time, his pain and injury interfere with his ability to concentrate or think.
24. His pain and injury have caused mild depression or anxiety.
25. He believes that the following statements are true:
    a. I am afraid that if I exercise, I will hurt myself.
    b. My body is telling me I have something dangerously wrong.
26. There has been a severe change with his ability to communicate by typing and writing. There has been no change regarding communication by hearing, seeing, or speaking.
27. Regarding his ability to work, I cannot do my usual work and can hardly do any work at all.

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SPECIFIC WORK AND FUNCTIONAL CAPACITY ACTIVITY ESTIMATE BY THE PATIENT AT PRESENT TIME:

1. He can do six to eight hours of the following:
    a. Sitting.

2. He can do four to six hours of the following:
    a. Walking.

3. He can do two to four hours of the following:
    a. Bending and twisting at the waist.
    b. Kneeling.
    c. Climbing stairs.
    d. Walking over uneven ground.
    e. Squatting.
    f. Climbing ladders.

4. He can do less one to two hours of the following:
    a. Repetitive neck motions.
    b. Static neck posturing.

5. He can do less than one of the following:
    a. Repetitive use of the upper extremity.
    b. Gripping and grasping with my left hand.
    c. Pushing and pulling on the left.
    d. Fine manipulation with my left hand.
    e. Reaching at shoulder level on the left.
    f. Reaching above shoulder level on the left.
    g. Repetitive use of the right upper extremity.
    h. Gripping and grasping with the right hand.
    i. Fine manipulation with the right hand.
    j. Pushing and pulling on the right.
    k. Reaching at shoulder level on the right.
    l. Reaching above shoulder level on the right.

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6. He can do zero hours of the following:
    a. Forceful use of the left upper extremity.
    b. Forceful use of the right upper extremity.
    c. Lifting and carrying 5 pounds.

MEDICAL RECORD REVIEW:

3.1.2019 P. Lang, MD. Hand surgery consultation for bilateral hand, wrist, and forearm pain. Patient is a right handed electrocardiogram technician who reports several month history of worsening bilateral hand, wrist, and forearm pain. Physical exam: Tinel;s sign in ulnar nerve at the elbow is negative bilaterally, Finkelstein's test is negative bilaterally, Watson's test negative bilaterally, forearm compartments are soft and nontender. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: recommend occupational hand therapist on a repetitive strain protocol. Optimize computer workstation ergonomic and use dragon software, follow up 6-8 weeks.

3.18.2019, 3.20.2019, 3.25.2019, 3.27.2019, 4.1.2019, 4.3.2019, 4.8.2019, 4.10.2019, 4.15.2019, 4.17.2019, 4.22.2019, 4.24.2019, 5.3.2019, 5.10.2019, 5.15.2019, 5.22.2019, 5.29.2019 A. Ting, OT., C. Wong, OT. Occupational therapy for bilateral hands. Diagnosis: pain in left hand. Pain in the right hand.

4.16.2019 P. Lang, MD. Hand surgery follow up for bilateral upper extremities. Patient reports improvement, used to have pain and bilateral hand, wrist and forearm, symptoms continue to wax and wane relative duplicate or use. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: patient made some adjustments to ergonomic workstation which provides some mild improvement of symptoms, will maintain work restrictions from computer use for the next six weeks, continue to work with occupational therapist call follow-up in six weeks. Work status: no computer youth.

5.28.2019 P. Lang, MD. Hand surgery follow-up for bilateral upper extremities. Patient symptoms remain unchanged. Patient did undergo a formal ergonomic evaluation of the computer workstation. The patient has been off of work for several weeks now and the group is persistent, patient reports he was on the phone and started having right wrist and forearm pain from simply holding the phone. Diagnosis: same. Plan: patient symptoms are classic for

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Neeti A. Bathia, M.D.
Musculoskeletal, Sports, Spine and Electrodiagnostic Medicine

George J. Rukkas, M.D.
Interventional and Chronic Pain Medicine

Alessandra A.E. Ross, M.D.
Orthopaedic Surgery, Sports Medicine

R. Elaine Lambert, M.D.
Rheumatologist

Marina Zyskina, N.P.

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repetitive strain injury, recommend we designate him permanent stationary pheasant permanent work restriction of no computer use. No follow-up needed.

PHYSICAL EXAM:

General:

Well-nourished, well-developed gentleman, in no acute distress.

Cardiac:

His extremities are warm and well perfused.

Pulmonary:

He is breathing comfortably on room air.

HEENT:

He has moist mucous membranes. He has tenderness to palpation in his cervical paraspinal muscles. He has 90 degrees of rightward and leftward rotation. He has C-spine flexion of 80 degrees, extension 20 degrees. All extremes of motions of the C-spine cause him to have neck pain. Lateral bending is 10 degrees bilaterally with pain at 10 degrees.

Musculoskeletal:

Bilateral 5/5 grip strength, bilateral 5/5 first to second and first to fifth digit grip strength. 5/5 biceps and triceps strength. Shoulder forward flexion is 160 degrees bilaterally with extension 50 degrees bilateral. Shoulder abduction is 120 degrees bilateral and adduction is 20 degrees bilateral.

David F. Smolina, M.D.
Interventional Pain Medicine
Mark J. Sontag, M.D.
Sports, Spine and Electrodiagnostics Medicine
Elaine S. Date, M.D.
Musculoskeletal, Spine and Electrodiagnostic Medicine
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Mikel Davenport, L.A.c
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Neuro:

He has negative Tinel's sign bilaterally at the carpal tunnel and negative Tinel's bilaterally at the cubital tunnel. He has 1/2 biceps reflexes, 0/2 triceps reflexes, and 0/2 brachioradialis reflexes. Sensation is normal in his upper and lower extremities to light touch.

Psych:

Regular speech, tone, and prosody. Logical thought process. Odd affect.

IMPRESSION:

1. Cervicalgia.
2. Bilateral forearm and hand pain.

DIAGNOSTIC STUDIES:

1. He requires a bilateral upper extremity nerve conduction study/EMG.
2. He requires a cervical spine MRI.

PERMANENT AND STATIONARY STATUS:

He is not permanent and stationary. He needs further diagnostic workup. Once that workup is done and the appropriate treatment is offered, he should then be examined for first permanent and stationary status.

CAUSATION:

100% causation is found to the 02/15/19 cumulative trauma injury.

APPORTIONMENT:

He does have a previous injury in his upper extremities. I would like to see documentation of this to appropriately apportion current injury and its role in his pain.

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WORK RESTRICTIONS:

He should lift no more than 5 pounds at the current time.

FUTURE CARE:

1. He requires medication for neuropathic pain, topical medications, and medications for myofascial pain.
2. He should continue to see Dr. Jamasbi for treatment.
3. He may require cervical epidural steroid injection.
4. He may require trigger point injections.
5. He requires twenty sessions of acupuncture.
6. He may require twelve sessions of physical therapy every six months for the next four years for flares.
7. He is an ideal candidate for a functional restoration program.

Thank you for allowing me to be your QME. Should you have any questions, please constitute them in a form of request for supplemental and I would be happy to address them.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,

Adam J. Stoller, M.D.

0123 27662624

CC: Mario Castro, Claims Adjuster
James Goines, Defense Attorney
Zachary Kweller, Applicant Attorney

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Dec 10, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:
***

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Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. However at the time, his insurance carrier was denying liability for his neck.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expire in March 2021. Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied and are currently being appealed. He has never trialed chiropractic therapy before, but he prefers to wait and see if acupuncture will be appeal approved prior to proceeding with chiro. He has also trialed massage therapy in the past although this actually aggrevated his symptoms more.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today. He also inquires about trialing Flector patch for topical relief of his symptoms.

We have received his QME report from Dr. Stoller. This is reviewed below.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who imformed him this would improve with time.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.

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5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Neck
Please submit as a change in material facts and attach Dr. Stoller report to RFA (uploaded to IMS on DOS 12/10/20).

This is a formal request for authorization of the medications within the "prescriptions" section of

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this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

1 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

***

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We do not have this report for review.

-Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied and is currently being appealed. We may consider trialing chiropractic therapy at his next visit should acupuncture remain denied.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19 and they expire in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left

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paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

-We reviewed the QME supplemental from Dr. Stoller. Per this report, he agrees that the patient's neck should be treated on an industrial basis and recommended that he see a specialist. In light of this finding, we will resubmit for the consult today.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. Patient states that he was recently let go from his employer.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. We will also trial him on Flector patch for topical relief. He has not trialed this yet, therefore no previous benefit can be documented. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. To expedite the process in which we may provide the appropriate treatment for our patient, please

consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's

decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Specialist Consults: The following has been recommended by the MTUS/ACOEM guidelines regarding Specialist Consults:

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Appropriate and Timely Specialist Referral:
Physicians should recognize when recovery and rehabilitation progress has stalled (use of guidelines and disability durations may assist in this process) or their capabilities in managing the affected worker have been exceeded, and seek appropriate specialist referral. (See critical nature of time in recovery from work disability discussed in the Iatrogenicity section.) This is related to avoidance of overtreatment (particularly continuation of ineffective therapy as previously discussed. Physicians may be hesitant to refer for a variety of reasons:

- Reluctance to accept their own limitations;
- Fear of 'losing' the patient to a specialist;
- Fear of negative reaction from the employer or insurer;
- Delays in the authorization process; and
- Lack of availability of healthcare providers willing to see workers, or specialist access in certain geographic areas or markets (including physical presence or willingness to treat workers' compensation cases).

As noted previously in the context of workplace depression, it is extremely helpful for physicians to develop ongoing referral networks, and to know the characteristics of referral sources whenever possible. Occupational medical providers should ensure that referrals are made to specialists whose approaches and quality of care are known and acceptable.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
6 Week(s)

CC:
Kweller, Esq., Zachary : 12/14/2020
Castro, Mario : 12/14/2020
Kweller, Esq., Zachary : 12/16/2020
Castro, Mario : 12/16/2020
UR, Chubb : 12/16/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 12/14/2020

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Pain & Rehabilitative
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Other Offices:
CASTRO VALLEY
SAN FRANCISCO
WALNUT CREEK
ROHNERT PARK
MANTECA

SUPPLEMENTAL REPORT

RE: SHOCKLEY, JONATHAN
CL#: 040519008736
DOB: 09/27/1978
DOI: 02/15/2019
DATE OF SERVICE: 12/03/2020

INTRODUCTION

This is a supplemental report to address **6 sessions of acupuncture**, which was requested on **11/06/20**.

I spent a total of 66 minutes of non-face-to-face prolonged service that relates to (face-to-face) care that has or will occur and ongoing patient management. Total time spent provided included the review of records from other physicians, review of diagnostic studies, and correspondence from CorVel Corporation dated 11/20/2020 for **6 sessions of acupuncture.**

Therefore, this report will be billed as 99358 x 1 unit. Please note that this 99358 service is prolonged to an initial service on 11/06/20.

This billing is to reflect extraordinary time spent in patient care that was not spent in direct face-to-face time. This includes time spent in other ongoing care management work as described in the Federal Register, Vol 81 No 220, and adopted by the Acting Administrative Director of the Division of Workers' Compensation, GEORGE P. PARISOTTO, on January 17, 2017.

Your denial letter dated 11/20/2020 states, "In this case, the patient has been authorized for 42 sessions of acupuncture which significantly exceeds guideline recommendations of a maximum of 12 sessions. Despite a substantial amount of acupuncture, the records do not establish associated significant sustained pain relief or any quantifiable functional improvements. The patient remains off work. IMR recently determined that additional acupuncture is not medically necessary and appropriate. Therefore, my recommendation is to NON-CERTIFY the request for Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb".

Please allow me to address this denial.

HISTORY OF PRESENT ILLNESS

The patient is a 42-year-old right-handed man who was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left. His left developed pain problems. He initially had pain around the wrist

area. The pain has gradually traveled up the arm towards the neck. He also has occasional hand pain.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 that shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI; the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

An EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side. With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy. We do not have this report for review.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. Previously, the patient had been attending acupuncture therapy with benefit.

At the present time, patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient reports that a few months back he took Gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. Due to the fatigue, the patient he had some bloodwork done that showed elevated TSH. He attributes this elevation in TSH is due to his use of Gabapentin and inquiries about having this level repeated.

We requested **6 sessions of acupuncture**; however, our request has been denied due to the reasons mentioned above.

PREVIOUS PHYSICAL EXAMINATION

Spine: There is TTP in the cervical paraspinal muscles. There was discomfort with lateral tilt of the cervical spine. Cervical spine lateral tilt to the left is 25% and lateral tilt to the right is 15%. Palpation of the volar aspect of the wrists were tender bilaterally. He has reduced 1+ biceps reflex and absent triceps and brachioradialis reflexes.

DIAGNOSTIC STUDIES

EMG was completed on 2/10/20 with Dr. Neeti Bathia,

Impression: Demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

MRI of the cervical spine dated 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6.

DISCUSSION

Regarding the denial of **6 sessions of acupuncture**, the UR physician felt that, "In this case, the patient has been authorized for 42 sessions of acupuncture which significantly exceeds guideline recommendations of a maximum of 12 sessions. Despite a substantial amount of acupuncture, the records do not establish associated significant sustained pain relief or any quantifiable functional improvements. The patient remains off work. IMR recently determined that additional acupuncture is not medically necessary and appropriate. Therefore, my recommendation is to NON-CERTIFY the request for Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb".

Please note that the patient had excellent benefits from prior sessions of acupuncture. He reported a reduction in his pain complaints from a 4-5/10 to a 2-3/10 on VAS, constituting a 10-20% reduction in his pain complaints for 2-3 days. He was able to do his ADLs better and there was overall improvement in his symptoms with acupuncture therapy.

However, it is very common for chronic pain patients to have acute flare-ups. They do have good days and bad days where their pain waxes and wanes as in this case. At the present time, patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity. On examination, there is TTP in the cervical paraspinal muscles. There was discomfort with lateral tilt of the cervical spine. Cervical spine lateral tilt to the left is 25% and lateral tilt to the right is 15%. Palpation of the volar aspect of the wrists were tender bilaterally. He has reduced 1+ biceps reflex and absent triceps and brachioradialis reflexes. Thus, indicating the presence of pain, inflammatory pathology and functional limitations for which Acupuncture is indicated by the guidelines.

This patent saw Dr. Gordon on 07/22/20 who does not recommend a surgical intervention. Massage therapy made his pain worse. He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. Patient reports that a few months back he took Gabapentin to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. Due to the fatigue, the patient had some bloodwork done that showed elevated TSH. He attributes this elevation in TSH is due to his use of Gabapentin and he discontinued its use. He also has a medical history of epilepsy. Given all these, we would like to minimize his reliance on oral pain medications by identifying alternative treatment options like acupuncture for his pain. He reported good benefit from prior session of acupuncture as documented above.

Please note that the new ACOEM guidelines do recommend Acupuncture as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to

be achieved. Also, there are studies, which support immediate Analgesic Effect of Acupuncture for Pain. We have documented an article below under supporting guidelines.

Please note this patient did have a PQME with Dr. Stroller on 1/23/20. Dr. Stroller did recommend that the patient have Acupuncture sessions under future medical care.
Acupuncture has the advantage of not using medications, which can be costly and have significant adverse side effects. Acupuncture as a non-medication conservative treatment has the potential to successfully reduce patient's pain after long-term follow-up, reduce the intake of costly pain medications and improve patients' overall function. We do believe that with this conservative treatment, we may also avoid invasive procedures for this patient. The goals of acupuncture treatment would be reduction in his pain, increase the ROM, improve his functional capacities, reduce his medication requirements, and allow him to better tolerate his ADLs. These acupuncture sessions will be done in conjunction with his home exercise program to obtain maximal benefits in terms of pain relief and function as well as to minimize the use of oral pain medications given his medical history. We will monitor his progress after each session. Therefore, our request for 6 sessions of Acupuncture for the neck, bilateral hands, wrists, and forearms should be authorized. The treatment is consistent with the guidelines.

SUPPORTING GUIDELINES:
Following has been recommended regarding **Acupuncture** in the ACOEM guidelines:
Acupuncture for Chronic Persistent Pain
Recommended.

Acupuncture is recommended to treat chronic persistent pain.
Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain, especially torso pain. Patients should have had NSAIDs and/or acetaminophen, stretching and aerobic exercise instituted and have insufficient results. Acupuncture may be considered as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to be achieved. Consideration is for time-limited use in patients with chronic persistent pain without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is only recommended to assist in increasing functional activity levels more rapidly and the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.

Benefits: Potential to improve pain control and advance functional exercises and conditioning.

Harms: Negligible in experienced hands. Pneumothoraces have occurred and puncture of other internal organs has occurred.

Frequency/Dose/Duration: Evidence does not support specific Chinese meridian approaches, as needling the affected area appears sufficient. Patterns used in quality studies ranging from weekly for a

month to 20 appointments over 6 months. However, the norm is generally no more than 8 to 12 sessions. An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures and would justify an additional 6 sessions, for a total of 12 sessions.

Indications for Discontinuation: Lack of improvement, lack of compliance with exercises, lack of incremental functional gain at the end of a treatment course, intolerance.

Rationale: There are multiple quality trials of acupuncture for treatment of many disorders, especially of low back pain (see Low Back Disorders Guideline). There are no quality trials evaluating acupuncture for treatment of non-specific chronic persistent pain. (One small study found no differences between sham and classic Chinese acupuncture.[243] There are quality studies evaluating acupuncture for the treatment of chronic pain including chronic neck pain, LBP, osteoarthrosis (especially of the knee), lateral epicondylitis, adhesive capsulitis of the shoulder, and headaches.[133, 244] Many different study designs have been used. These include comparisons with shams that insert needles in non-traditional locations, minimal acupuncture with superficial needling, shams that do not insert needles, and comparisons with non-acupuncture treatments. Some studies have combined the acupuncture with electrical currents, and others have applied electrical currents to acupuncture sites. There is no clear benefit of electroacupuncture over needling. There remain some questions about efficacy of acupuncture,[245, 246] with concerns about biases, e.g., attention and expectation bias, in these study designs. Some, but not all studies, suggest persistence of meaningful benefits beyond the duration of treatment.

The majority of studies have demonstrated that there is no benefit of traditional Chinese acupuncture over other types of acupuncture. The evidence to address that question prominently includes all of the highest quality studies.[247-249] One study that evaluated acupuncture in trigger points found benefit from needling over either traditional acupuncture or acupuncture applied to other sites,[250] but that study has not been replicated. There is similarly a suggestion that superficial needling may be as efficacious as deep needling of muscles,[251] but not all studies have found that result.[252] Thus, aside from having identified that there does not appear to be a benefit from traditional acupuncture over other forms of acupuncture, other aspects of needling need further study. Evidence of benefits from acupuncture is strongest for LBP (see Low Back Disorders). However, there is consistent evidence of benefit for chronic neck pain.[250, 253-255] There are few quality studies evaluating the utility of acupuncture for treatment of tender and trigger points and they tend to have significant design flaws which limit the strength of conclusions. Efficacy of acupuncture for this indication is suggested by the highest quality study.[250]
Acupuncture when performed by experienced professionals is minimally invasive, has minimal adverse effects, and is moderately costly. Despite significant reservations regarding its true mechanism of action, a limited course of acupuncture may be recommended for treatment of certain specific disorders[244, 256-265] (see other guidelines, including Elbow Disorders and Cervical and Thoracic Spine Disorders). Acupuncture is minimally invasive, has low adverse effects, is moderately costly, appears to have some evidence of efficacy, and is recommended.

Evidence: There are no quality studies evaluating acupuncture for the treatment of chronic persistent pain.

1. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5676441/

This is the first systematic review and meta-analysis of RCTs on the immediate effects of acupuncture for the treatment of disease-related pain. We included a total of 13 studies in our review. The results showed statistically significant differences between the efficacy of real acupuncture and those of sham controls for all types of pain included in this review. The SMDs between real acupuncture and control sham acupuncture were lower than those between real acupuncture and a no-acupuncture control. In addition, acupuncture appeared to be more effective than analgesic injection (at intragluteal site with analgesic or local infiltration with anesthetic) in reducing pain. The meta-analytic effect sizes were not similar across pain conditions. There was no evidence of any significant harm caused by acupuncture in any of the RCTs. However, it should be stressed that this lack of evidence is based on the results of a few small trials with a high risk of bias. Therefore, a careful interpretation is warranted before arriving at a positive conclusion.

Compared with the assessment of the cumulative effects of acupuncture, the determination of the immediate effects could be relatively easy; that is, it is not necessary to consider the treatment endpoint or follow-up duration. Acupuncture also has a very low drop-out rate. For the systematic review and meta-analysis of the efficacy of acupuncture, various factors could affect the outcomes in the evaluation of the cumulative effects of acupuncture, including the total number of treatment sessions, treatment period, and variation in the end points, such as those of pain and function measurements at different times. Because of the exclusion or minimization of these variable factors, the evaluation of the immediate effect may closely reflect the actual analgesic effects of acupuncture stimulation.

Primary analgesic agents, such as morphine, can be used for the management of both acute and chronic pain. The peak effect of morphine is at around 20 min when administered intravenously and at 60 min when administered orally, while the duration of its effect is between 3 and 7 h [52, 53]. The results of our systematic review and meta-analysis indicate that acupuncture shows an immediate analgesic effect as the treatment of chronic pain. In general, the duration of onset of the effect of acupuncture is 15–30 min [15, 54]. The duration of the analgesic effect following a single session of acupuncture is about 3 days, although this duration is not consistent [55]. Therefore, the immediate effect of acupuncture may have clinical significance as an alternation for analgesic medication or as a reasonable method for pain treatment. Moreover, the success of acupuncture as a treatment of pain is often gauged by the number of clients retained in pain management or treatment facilities. The apparent benefits of the immediate analgesic effect of acupuncture may entice patients to receive long-term acupuncture treatment willingly or open to other forms of acupuncture options. Therefore, the immediate success of acupuncture treatment should not be overestimated. In present study, we did not find a greater immediate pain relief effect of acupuncture for acute pain compared with the sham acupuncture (P = 0.46). However, our sensitivity analysis showed that real acupuncture was more effective than the sham acupuncture in reducing acute pain immediately, if excluding the study by Zhang et al. [42]. This might be explained by some variable factors, such as the types of sham acupuncture, control procedures, and outcome measures. Further rigorous studies with standardized methodologies are required to test the efficacy of acupuncture for the treatment of acute pain.

The design of a control group is a continuing challenge for clinical trials of acupuncture. Many clinical trials were unable to detect statistically significant differences in the treatment efficacies between their acupuncture treatment and control groups in terms of any of the outcome measurements [56–58]; the authors of these trials concluded that acupuncture was no more effective than any sham interventions, for example, skin-touch sham (nonpenetrating) and skin-penetration sham in reducing pain. Based on the results of this systemic review and meta-analysis study, we found real acupuncture treatment has statistically significantly greater immediate pain relief than nonpenetrating sham acupuncture (SMD, −0.70; 95% CI, −1.21 to −0.20; 4 RCTs), but not these of penetrating sham acupuncture (SMD, −0.46; 95% CI, −1.11 to 0.18; 5 RCTs). Interestingly, when we excluded the study by Zhang et al. [42], we found real acupuncture was more effective than the sham acupuncture in relieving pain immediately after acupuncture treatment, which indicates some sham acupuncture treatment is not inactive.

Our systematic review and meta-analysis study focuses on the immediate analgesic effect of acupuncture. This raises some interesting questions. The first question is whether the immediately analgesic effect following the first acupuncture treatment can be used as a predictor for the success of subsequent or long-term acupuncture treatment. Most clinical trials focused on analgesic effects after multiple acupuncture treatment. Few studies assessed analgesic effects after both immediate posttreatment and multiple acupuncture treatments. Therefore, further studies must be performed to clarify this issue. The second question is whether the immediate acupuncture analgesic effect and cumulative analgesic effects following repeated acupuncture treatments share common mechanisms. Thus far, there is no clear documentation in regard to the underlying mechanisms of these two analgesic effects. Based on the available data published, needle insertion of the local acupuncture points triggers the release of adenosine and changes of fibroblast organization at the loose connective tissue layer [59–61]. The cumulative analgesic effects following repeated acupuncture treatments on the brain differ from the immediate analgesic effect after one acupuncture treatment. The immediate analgesic effect of acupuncture was a result of an extensive brain activation at selective pain-related regions [62]. However, the cumulative analgesic effects of acupuncture indicated bimodal habituation—a positive brain response appeared at the beginning of acupuncture stimulation, which then declined and became negative towards the final stages [28]. From neurohormonal prospective, a single acupuncture treatment can facilitate the release of opioid peptides [19]. Repeated administration of electroacupuncture leads to the development of opioid tolerance [63, 64]. Therefore, although acupuncture has both immediate and cumulative analgesic effects following repeated treatments, underlying mechanisms may be different.

Our systematic review and meta-analysis study has several limitations. Only English and Chinese literatures were reviewed in present study and potential data from studies published in other languages might exist and were ignored, which decreased the credibility of the results in present study to some extent. We included RCTs evaluating various types of pain, including chronic neck pain, LBP, and knee pain. In fact, accumulated work has shown that acupuncture is beneficial in treatment of various pain syndromes. The effects of acupuncture on nonspecific pain may share the similar underlying mechanisms. In traditional Chinese medicine, disease-related pain results from stagnation of energy "Qi" flow within meridians. Pain is treated locally or distally via acupuncture points further along the meridian, drawing energy away from the pain. Recently, the neurophysiology of acupuncture has been investigated extensively. Local anesthesia at the needle-insertion sites completely blocks the immediate analgesic effect of acupuncture, indicating that these effects are dependent on intact neural conduction. The immediate analgesic effect on various types of pain may be involved in the nociceptive pathway, including descending noradrenergic and serotonergic pathways [65]. In our

meta-analysis, a high level of heterogeneity may be resulted from the baseline values, the acupuncture manipulation, acupuncture points selected, and the duration and frequency of treatment. Our review has a number of strengths. First, our search for relevant studies was extensive. Key Chinese databases were explored in addition to the English databases. Second, we assessed the differences in the immediate analgesic effect of acupuncture between real acupuncture and different types of controls. Third, the review only evaluated RCTs, which have study designs appropriate for the determination of the effects of intervention.

In conclusion, this review facilitates a better understanding of acupuncture stimulation and its immediate analgesic effect for disease-related pain. The results of our systematic review and meta-analysis suggest that evidence of the immediate analgesic effect of acupuncture is encouraging, but not convincing. Nevertheless, our review has yielded interesting and innovative findings and provided impetus to further investigations. Further rigorous, high-quality, randomized controlled trials comparing acupuncture with nontreatment and sham acupuncture without skin penetration are required to evaluate the immediate analgesic effect of acupuncture.

Kindly reconsider authorization for **6 sessions of acupuncture for the neck, bilateral hands, wrists, and forearms.** We hope we have clarified the medical necessity for our request and this is authorized soon. Please note that this patient meets the guidelines criteria for warranting treatment and we will continue to keep the insurance updated regarding this patient's progress.

Further delay of this patient's treatment would only serve to prolong his suffering and increase the overall cost to the California Workers' Compensation system through prolongation of the utilization review process.

"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true."

"I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

This communication and any files transmitted with it may contain information that is confidential, privileged, and exempt from disclosure under applicable law. It is intended solely for the use of the individual or entity to which it is addressed. If you are not the intended recipient, you are hereby notified that any use, dissemination, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender and destroy the related communication.

You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law

Supervising:

Babak J. Jamasbi, M.D., F.A.C.P.M.

Performing:

Thrisha Kashinath PA-C

Thrisha Kashinath, PA-C

Signed this 3rd day of December 2020 in Alameda County.

CC:

Mario Castro, Claim Adjuster
Fax (800) 664-1765

Zachary Kweller, Attorney at Law
Fax (866) 819-6169

Pain & Rehabilitative
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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Nov 06, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

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Patient is presents via Facetime to follow up on pain in his arms and bilateral hands.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied on appeal.

He met with Dr. Gordon for a surgical consult on 7/22/20. We have this report for review today.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. Howèver this caused extreme fatigue which he still feels is occurring. Due to the fatigue, the patient he had some bloodwork done that showed elevated TSH. He attributes this elevation in TSH to his use of gabapentin and inquires about having this level repeated. This is discussed below.

Medical History:
***

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***

PSYCH/SOCIAL HISTORY

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The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of acupuncture 97813, 97814, 97026, 97124
Please submit as a change in material facts and attach Dr. Gordon's consult located in IMS documents.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm

M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
1 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1 update sig
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We do not have this report for review.

-Given that Dr. Gordon does not recommend a surgical intervention, we will resubmit for acupuncture with a change in material facts with his report attached.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the

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bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

-QME with Dr. Stoller has been postpone until 1/2021.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. Patient states that he was recently let go from his employer.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving however so we will not be ordering a repeat level at this time.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for

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reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer

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requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Lidoderm Patch: The following has been recommended regarding Lidoderm Patch in the MTUS/ACOEM guidelines

Lidocaine Patches for Neuropathic Pain
Moderately Recommended.

Lidocaine patches are moderately recommended for treatment of postherpetic neuralgia when there is localized pain amenable to topical treatment.

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Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – Moderate

Indications: Moderate to severe peripheral neuropathic pain that includes superficial pain generation (e.g., postherpetic neuralgia), peripheral nerve injury, and possibly some toxic neuropathies with superficial pain generation [1190-1192]. One quality trial [1193] evaluated treatment of CTS with pain as a central complaint when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted.

Benefits: Modest improvements in pain

Harms: Dermal irritation and intolerance; may have adverse systemic effects if widespread applications of numerous patches

Frequency/Dose/Duration: Lidocaine patch 5%, up to 4 patches applied up to 12 hrs/day. Duration of use may be ongoing for chronic, localized pain, although most patients do not require indefinite treatment. Caution is warranted regarding widespread use of topical anesthetics for potential systemic effects from widespread administration.[221] Topical 5% lidocaine medicated plaster has also been used [1194-1197], as well as lidocaine spray [1198]

Indications for Discontinuation: Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least 2 weeks.

Rationale: Lidocaine patches have been reportedly effective for treatment of localize peripheral neuropathic pain [1190-1192]. Topical lidocaine has been suggested to improve pain associated with CTS and appears to be somewhat more effective than naproxen.[222] This provides some basis for a consensus recommendation for treatment of peripheral neuropathic pain. Lidocaine patches are not invasive, generally have a low adverse effect profile, are moderately costly, have some evidence of efficacy for treatment of carpal tunnel syndrome and thus are recommended for treatment of peripheral neuropathic pain. It is not recommended for central neuropathic pain.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization,

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randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is one high-quality study and moderate-quality studies incorporated into this analysis.

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the

supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
4 Week(s)

CC:
Kweller, Esq., Zachary : 11/09/2020
Castro, Mario : 11/09/2020
UR, Chubb : 11/09/2020
Kweller, Esq., Zachary : 11/13/2020
Castro, Mario : 11/13/2020
UR, Chubb : 11/13/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 11/16/2020

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December 3, 2020

MEDICAL LEGAL SUPPLEMENTAL REPORT

RE: SHOCKLEY, Jonathan
DOB: 09/27/1978
INSURANCE: Chubb Group Insurance Company
CLAIM #: 7173815490
DOI: 02/15/2019
EMPLOYER: CardioNet

Dear Concerned Parties,

I am in receipt of supplemental medical records for Jonathan Shockley. I have spent 3 hours in medical record review with the help of Doctus reviewing 470 pages of records. I have spent 45 minutes drafting and editing this report. This will be billed as an ML-106 with 3 hours and 45 minutes spent.

Medical Record Review:

1. Deposition of Jonathan Shockley, 10/10/19
2. Workers' Compensation Claim Form (DWC 1), 02/19/19
3. Adam J. Stoller, MD, 04/01/20, 04/06/20, 09/20/20

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4. Andreas Schwerte, LAc, participated in acupuncture therapy sessions from 11/05/19 to 06/23/20

5. Annie Ting, OT, 03/18/19

6. Babak J. Jamasbi, MD, 10/21/19

7. Golden Gate Hand Therapy, participated in occupational therapy sessions from 03/18/19 to 05/29/19

8. Golden Gate Hand Therapy, participated in physical therapy sessions from 03/18/19 to 06/05/19

9. Jessica Aikin, PA-C/Babak J. Jamasbi, MD, 11/22/19, 01/10/20, 04/24/20, 05/29/20, 06/12/20, 07/10/20, 08/07/20, 09/04/20, 09/25/20, 11/06/20

10. Julis Fellows, PA-C/Babak Jamasbi, MD, 01/15/20, 02/26/20, 03/25/20

11. Leonard Gordon, MD, 07/22/20

12. Neeti Bathia, MD, 02/10/20

13. Patrick O. Lang, MD, 03/01/19, 04/16/19, 05/02/19, 05/14/19, 05/28/19

14. Diagnostic Examination Reports:

a. Cross-Table MRI of Cervical Spine without Contrast, 04/03/20

02/19/19 Workers' Compensation Claim Form (DWC 1). (DOI: 02/15/19). Employee sustained cumulative repetitive stress injury to upper extremities, hands, wrists and forearms.

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03/01/19 Patrick O. Lang, MD - The Hand Center Hand Surgery Consultation. HPI: Patient presents for evaluation of his bilateral hand, wrist, and forearm pain. He reports a several month history of worsening bilateral hand, wrist, and forearm pain. He reports that his job requires very intense and prolonged use of a computer and mouse. The symptoms arose in the setting of at work. He does not recall any other specific history of trauma. He reports vague and diffuse bilateral hands, wrist, and forearm pain. Past Surgical Hx: Removal of bone spur from the foot and two prior Achilles tendon operations. Meds: Aspirin and Advil. Dx: Bilateral upper extremity repetitive strain injury. Tx Plan: Patient had a lengthy discussion with patient regarding his diagnosis of repetitive strain injury. The symptoms are undoubtedly related to his work on a computer. Recommended him to begin working with an occupational hand therapist on a repetitive strain protocol. Also talked with him about optimizing his computer workstation ergonomics and using dictation software is much as possible. All questions are answered. Work Status: TTD or no work. F/u in 6-8 weeks to reassess his symptoms.

03/18/19 Annie Ting, PT - Golden Gate Hand Therapy Physical Therapy Initial Evaluation. CC: Patient presents for physical therapy evaluation. He uses mouse for work primarily analyzing EKG. He reports over time it got worse on both hands. He stopped working 1 month ago because he realized if he kept going, it would get worse. He reports he is not currently very optimistic about going back to work and will likely return part-time rather than full time. He reports most of his coworkers had a bad set up and also had bad

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posture. He rates his pain as 3/10 at worse, 1/10 at best and currently 1/10. Dx: 1) Pain in right hand. 2) Pain in left hand. Tx Plan: Recommended to continue physical therapy as scheduled.

03/18/19 Annie Ting, OT - Golden Gate Hand Therapy OT Initial Evaluation. CC: Patient is a RHD who uses a mouse for work primarily analyzing EKG. He reports over time it got worse on both hands. He stopped working 1 month ago because he realized if he kept going, it would get worse. He uses a mouse mostly for work. He reports that he is not currently very optimistic about going back to work, and will likely return part-time rather than full time. He reports most of his coworkers had a bad set up and also had bad posture. Dx: 1) Pain in right hand. 2) Pain in left hand. Tx Plan: Recommended occupational therapy 1-2x/week for 6 weeks.

04/16/19 Patrick O. Lang, MD - The Hand Center of San Francisco, Inc PTP's Progress Note (PR2). CC: Patient has been under care for treatment of his bilateral upper extremity repetitive strain injury. His current occupation requires intensive sustained a use of a computer and mouse. This has generated a vague bilateral upper extremity pain that has been refractory to conservative management. He continues to report pain in multiple locations in the bilateral hands, wrists, and forearms. These symptoms continue to wax and wane relative to his computer use. Dx: Bilateral upper extremity repetitive strain injury. Tx Plan: Patient has a clear case of repetitive strain injury affecting his bilateral upper extremities. He has made some adjustments to his ergonomic workstation and has seen some

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mild improvement in his symptoms. He continues to report that his pain is exacerbated by a computer use. Will maintain his work restrictions from computer use for the next 6 weeks. He will also continue working with his occupational hand therapist. Work Status: RTW/Modified duty. Restrictions: No computer use. F/u in 6 weeks. He is approaching Permanent and Stationary status.

05/02/19 Patrick O. Lang, MD - The Hand Center Work Status Report. Dx: RSI. Work Status: Okay to return to work for ergo evaluation.

05/14/19 Patrick O' Long, MD Correspondence. Patient has been under care for treatment of his bilateral upper extremity repetitive strain injury. His symptoms are directly related to his work as a cardiology data analyst. He spends long hours on a computer every day in the course of his normal work. He was put on temporary total disability on his initial visit on 03/01/19 until 04/10/19. Examiner has agreed to place him on modified duty with the restriction of no computer use until his symptoms improve from 04/10/19 through 06/01/19. This is not an open ended work restriction, and will reevaluate his status in a few weeks. Hope is that he will be able to return to work with no restrictions following the next visit, as examiner has no additional treatment to offer him. He is continuing to work with his occupational hand therapist in the meantime. In summary, he will remain on modified duty with the restriction of no computer use until the first week of 06/2019. At that point, anticipated that he will be Permanent and Stationary status with no residual work restrictions.

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05/28/19 Patrick O. Lang, MD - The Hand Center of San Francisco, Inc Treating Physician's Permanent and Stationary Report/PR-3. (DOI: 06/25/18) Hx of Injury: Patient was referred for bilateral upper extremity pain. His symptoms arose in the setting of his work as an EKG technician. His job is a quota-based position that requires him to analyze large number of EKG reports on a computer monitor. This involves extensive mouse clicking in a repetitive fashion. In the course of his work, he developed a diffuse of bilateral hand and forearm pain. His problem has been managed conservatively with work restrictions and occupational hand therapy. In addition, he has undergone a formal ergonomics evaluation of his computer work station. CC: Patient continues to repot vague bilateral hand and wrist and forearm pain. He has been off work for several weeks now, but the symptoms are persistent. He reports that he was talking on phone just a few days ago and had a significant exacerbation of his right wrist and forearm pain from simply holding a phone. Dx: Patient with bilateral upper extremity repetitive strain injury. Tx Plan: Had a lengthy discussion with him regarding his current status. Unfortunately, have no treatment to offer him. His symptoms are classic for repetitive strain injury and are clearly related to the nature of his work as a reviewer of EKGs. Told him that the prognosis for these sorts of repetitive pain symptoms is highly variable. The suspicion is that the symptoms will eventually resolve. The timeline is not clear. His emphatic about being unable to use a computer as any minor use of computer causes flares in his symptoms. Therefore, recommended to designate him Permanent and Stationary with the permanent restriction of no computer use. No future medical care is needed. Work Status: RTW/modified duty. Restrictions: No use of computer. No f/u needed.

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05/29/19 Golden Gate Hand Therapy Patient participated in occupational therapy sessions from 03/18/19 to 05/29/19.

06/05/19 Golden Gate Hand Therapy Patient participated in physical therapy sessions from 03/18/19. 06/05/19.

10/10/19 Deposition of Jonathan Shockley taken on 10/10/2019: Vol I

Page 8 – The applicant did not know how to drive. Page 10 – At the time of the deposition, he was on baby aspirin, which he took every day. It was not prescribed, and he took it for its anticancer properties. Page 11 – He took Advil as needed for the symptoms in his hands intermittently from the beginning of 2019. He took Advil before going to bed, if the pain in his hands was severe. He took it whenever he experienced a flare-up. The applicant claimed cumulative trauma through February 2019. Page 12-14 – Approximately in 2009, or about ten years ago, he had some pain in his right wrist that had developed over time. He went to Dr. Robert Markison, a doctor on Van Ness Street in San Francisco, for one visit. The doctor taught him how to do an exercise that would send warmth to his hands through some type of a focus. He stated that the treatment was almost meditative. He had done the exercises that the doctor instructed him to do. At the time of the deposition, he had claimed injury to his bilateral upper extremity, including his hand, fingers, and right wrist. Page 15 – After the one appointment with Dr. Markison, the applicant's right wrists symptoms resolved. He had performed the meditative techniques to reduce the stress in his wrist only a few times. He stated that the pain went away on its own within a few weeks, and mostly not because of the

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exercises. He did not recall missing any time from work due to the right wrist symptoms. Page 17 – He recalled that he had a visit with Dr. Markison only for his right wrist symptoms, and not for his right hand. Page 18 – He had a prior workers' compensation claim in 1996 or 1997, for issues to his ankle or feet. Page 19 – The applicant agreed that he had a 03/25/1998 left foot injury against Boston Ballet and a 12/02/1998 injury to both his feet against the Tulsa Ballet Theater. After the 03/25/1998 left foot injury, he received medical treatment and then returned to work. Page 20 – He did not recall receiving medical treatment for the 12/02/1998 injury. He agreed that he had a 05/18/2001 injury to his Achilles against the San Francisco Ballet Association. Page 21-23 – He received medical treatment, but then had to retire from his ballet career due to the Achilles injury. He had had another injury to his same right Achilles tendon on 09/24/2001 against the San Francisco Ballet Association. He stated that he had two surgeries to his right Achilles. The second surgery was partially successful. He stated that other than those surgeries, he underwent surgery for his adenoids and sympathectomy in San Francisco in 2000 or 2001. He also underwent Lasik surgery for his eyes and had a bone spur removed surgically from a toe in his right foot, in 2000, before his Achilles surgery. Page 24 – In the last five years, he had been to the ER at Saint Francis in San Francisco several times. Once, his urine was red, another time, he had difficulty breathing, and once it was for a kidney stone. Page 26 – He started working at Biotelemetery, his employer at the time of the deposition on 06/25/2018. He last worked there on 02/15/2019. Page 27&28 – Before that, he worked for Pacific Chess School for about two years. He stated that he went to several different schools in San Francisco to teach chess. He agreed that his job duties included the use of his hands because he was teaching chess. He stated that the job was part-time, and he worked only once or twice a week, for an hour and a half. He affirmed that

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he did not feel any pain in his right wrist or right hand while teaching chess. Page 29 – Before that, he worked part-time for the Berkeley Chess School in 2015 or 2016. It was an after-school activity for the children. He taught for about an hour or an hour and a half, about four or five times a week. Page 30 – He estimated that he taught for about eight hours a week. Before that, approximately from 2011 to 2014, he worked for the San Francisco Youth Ballet. Page 31 – He agreed that he had retired as a professional ballet dancer after his second ankle surgery in 2002 or 2003. After that, as he had not recovered, he considered himself retired. In 2001 after the injury, he still had hopes. Page 32 – He worked part-time at the San Francisco Youth Ballet. He estimated that he worked there for about ten hours a week, teaching children ballet. Page 33 – He affirmed that he last worked with Biotelemetry on 02/15/2019. Since then, he had experienced pain in his right big toe. He stated that he wore a toe spacer and he was walking a lot. The right big toe pain started about a few weeks ago. The doctor did not know what the cause of the pain was, and he was already feeling better. The applicant stated that the bone spur surgery that he had in 2000, was to his right big toe itself. At the time of the deposition, the pain in the right big toe had resolved to a substantial extent. Page 35 – The applicant's job title with Biotelemetry was that of a Tech 1. His job duties for the first few months included editing, classifying EKGs that came in through mobile cardiac devices that people wore and answering phone calls about a particular EKG. Then, the job was more purely just processing the EKGs straight from the computer. He answered phone calls for some time too. Page 36 – He agreed that while processing EKGs, he used the keyboard and a mouse. He worked for about 40 hours a week. He stated that of his eight-hour shift, he spent about seven hours on the computer. Page 37 – He agreed that he developed the pain in his hand and wrist over time. His right hand, right wrist, and

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right forearm started hurting first. He then switched to a left mouse and incorporated a pedal for clicking to take some load off his right hand. Page 38&39 – He explained that he used a vertical left mouse and he clicked the pedal with his foot. He agreed that it was like a bass drum, to spread the load. He stated that due to the clicking, he started experiencing symptoms in his foot too. Those symptoms resolved. He agreed that with the left mouse and the pedal, he used his left hand to move the mouse and his foot for the clicking function. He had initially started using the left mouse, and then after some time had incorporated the pedal. Page 40 – After a while, he started experiencing the symptoms in his left upper extremity too. He stated that he was mostly right-handed. The day he stopped working, he experienced pain in both his hands, but it was slightly worse in his right hand. The right hand flared up more easily than his left. As he was right-handed, he tended to use his right hand more often. Page 41 – The applicant agreed that he had received medical treatment from Dr. Patrick O. Lang. Dr. O. Lang placed him on permanent work restrictions and said that he was permanent and stationary. He had restricted him from working on the computer and had told him to limit or reduce his hand activity. He had told the doctor that lifting anything or even holding or using his phone caused him pain in his hand. Page 42 – The work restrictions in the 05/28/2019 report stated modified duties with no use of the computer. The applicant stated that his employer was unable to accommodate that, as most of his duties were involved the use of the computer. The applicant affirmed that he had not returned to work at Biotelemetry. Page 43 – He confirmed that he had issues with his right-hand fingers. He stated that he had some issues in the tendons of the left hand as he moved and used his fingers. He reconfirmed that he had symptoms in his right forearm, right wrist, right hand, and right fingers, and when he experienced a flare-up, the pain radiated to his right shoulder, almost touching his neck. Page

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44 – He stated that most of the time, it was from his elbow to his fingers, bilaterally. Page 45 – The applicant stated that the intensity of his flare-ups differed. He stated that at its maximum, he experienced pain at 7/10 or 8/10 during a flare-up. He had experienced two of those flare-ups since he had stopped working. Page 46 – He added that he experienced more of the lesser intense flare-ups when his activity was greater than a certain amount, every day. On 05/28/2019, he had told Dr. O. Lang that the therapy he received was not beneficial. Page 47 – In his report, the doctor had stated that he did not have any further medical treatment to offer the applicant. However, he had recommended modified duties with restricted use of the computer. The 5/28/2019 permanent and stationary report from Dr. O. Lang was marked and identified as Exhibit 1. Page 48 – The applicant had a computer at home, and he used it. He had purchased modifications for the computer at home so that he could use it within the restrictions provided by Dr. O. Lang. He had bought a head pointer that worked by moving one's head, a set of pedals for clicking, and the Dragon speaking software. Page 49 – He could, thus, use the computer without using his hands. However, as he was required to use his neck, he did not do that for too long as it caused soreness in his neck. His neck pain forced him to limit the amount of time that he spent on the computer using the modifications. Also, since he had toe pain, it hurt him to use the pedal, too. He attributed his neck pain to his modified use of the computer and his phone. He stated that he used a mouth stick and a physical head pointer that he strapped to his head with a metal point and he moved it in a certain way while using his phone. Using the voice control on his phone tired his voice too. Page 50 – He affirmed that he had told Dr. O. Lang about the head mouse, the pedals, and the Dragon speaking software. The doctor had encouraged the applicant to minimize hand use. The applicant had told Dr. O. Lang that he experienced neck pain on using the head pointer

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for too long. Page 51 – He had experienced neck pain from the first day that he started using the head pointer. He stated that he had to coordinate the movement of his feet and his head for using the pedal and the head pointer. He had purchased the head pointer for his computer several months ago, after his last day at work. Page 52 – He did not recall when he had exactly told Dr. O. Lang about the head pointer bothering his neck. Dr. O. Lang had been the only person that he had treated with for his workers' compensation injury. Page 53 – He received only physical therapy through Dr. O. Lang. He stated that he received about 20 sessions of physical therapy. Page 54 – The doctor had not done any imaging or diagnostic studies. Page 55&56 – The 03/01/2019 initial report from the doctor was marked and identified as Exhibit 2. The applicant confirmed that Dr. O. Lang had not physically examined his arms even once. However, the 03/01/2019 initial report stated that the examination of the bilateral extremities revealed no deformity, the Tinel's sign, and the Finkelstein's test were negative and that the applicant had normal range of motion in his wrists and digits, bilaterally. The applicant reiterated that he could not use his head pointer for too long as it gave him neck pain. The applicant had treated with Dr. O. Lang from 03/01/2019 through 05/28/2019. Page 57 – The applicant had bought the head pointer after 02/15/2019, but he had already been using the pedals and the Dragon speaking software when he was still working with Biotelemetry. That was as both his hands were in pain. Page 58 – The applicant confirmed that Dr. O. Lang's 05/28/2019 permanent and stationary report restricted the applicant from using the computer.

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10/21/19 Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group Initial Evaluation. CC: Patient was injured during the course of his usual and customary work. He has worked as an EKG technician, which requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left. His left developed pain problems. He initially had pain around wrist area. Pain has gradually traveled up the arm towards the neck. He also has occasional pain. His pain is constant at low level, exacerbated by hand activity. Pain wakes him up at night. When he does not do anything, his hand does not hurt. Pain increases with activity, especially computer work, cell phone use, and writing. Inactivity, Advil, deep massage makes the pain better. Dx: Cumulative trauma injury to both upper extremities. Tx Plan: On exam, patient had normal range of motion in all the joints of his upper extremities. He does have cumulative trauma injury which is brought on by activity. Recommended 12 sessions of acupuncture and 12 sessions of soft tissue mobilization/massage therapy. If he does not respond to conservative measures, an evaluation at a CARF-certified FRP program would be indicated. Work Status: Not Permanent and Stationary. Work Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4 weeks.

11/22/19 Jessica Aikin, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group Progress Note. CC: Patient presents for followup on pain in his bilateral hands. He continues to report bilateral hand pain, right greater than left. Occasionally pain radiates up his arms towards his neck. Pain is worse with repetitive use of

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his upper extremities, excessive typing or computer work. Pain is better with conservative treatment. He reports having pain flair with the use of massage therapy, this dramatically increased his pain. He also has been going to acupuncture treatment. This does help with his pain. With regard to medication, he does take Advil as needed for pain. Dx: Other long term (current) drug therapy. Tx Plan: Prescribed Voltaren 1% gel. He will continue with acupuncture treatment, he has approximately 7 appointments remaining. Before acupuncture treatment his pain is a an 4-6/10, this will decrease down to approximately down to a 2-3/10, this allows him to use his hands more. Will request for 6 additional sessions so he can continue this. Okay to discontinue massage therapy, TENS dramatically increased his pain. If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated. He is scheduled for QME on 01/23/20. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4 weeks.

01/10/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for f/u on his bilateral hand pain. He denies any changes to his pain complaints. He continues to report bilateral hand and arm pain, right greater than left. Occasionally pain radiates up from his hands into his bilateral forearms and up towards his neck. Pain is worse with repetitive use of his upper extremities, typing, or computer work. Pain is better with conservative treatment. He reports improvement with acupuncture and has been approved for 6 additional sessions.

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Massage therapy did not really help as the practitioner was only able to focus on his hands while it is really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands. With regard to medication, he reports improvement with Voltaren gel. Requested refill. Dx: 1) Other soft tissue disorders related to use, overuse and pressure, left forearm. 2) Other soft tissue disorders related to use, overuse and pressure, right forearm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right upper arm. Tx Plan: Prescribed Voltaren gel. Approved for 6 additional sessions of acupuncture. Requested 6 sessions of massage therapy. FRP would be indicated if he does not respond to conservative measures. He is scheduled for QME on 01/23/20. Work Status: Off work. Not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

01/15/20 Julis Fellows, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for followup of pain in his bilateral hands. He presents for an early followup currently due to a flare up of pain. He reports increased pain, right more than left, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes his pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity. He reports improvement with acupuncture treatment and he has recently been approved for 6 additional sessions. With regard to massage therapy, he

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reports that this did not really help as the practitioner was only able to focus on his hands, while it is really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands. Dx: 1) Other soft tissue disorders related to use, overuse and pressure, left forearm. 2) Other soft tissue disorders related to use, overuse and pressure, right forearm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right upper arm. Tx Plan: Patient was injured during the course of his usual and customary work. He has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left. He presents due to an acute increase in his upper extremity symptoms. On exam he has full ROM of the bilateral shoulders with some discomfort, His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbows. He has never had an EMG of the upper extremities to assess for ulnar or median neuropathy before. Currently, given that his symptoms have persisted for greater than 6 months and responded only minimally to conservative treatment, will request for an EMG. Pending the results, may consider a referral to a specialist. He has been approved for 6 more acupuncture sessions and will schedule these. He is scheduled for QME on 01/23/20. Will review this report when available. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing or pulling greater than 5 lbs. F/u in 4-6 weeks.

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02/10/20 Neeti Bathia, MD - Remedy Medical Group Progress Note. CC: Patient c/o bilateral hand pain. He has been referred for an upper limb electrodiagnostic study to evaluate bilateral hand pain. Dx: 1) Pain in left elbow. 2) Pain in left hand. Tx Plan: Electrodiagnostic study performed. Full report scanned into chart and results reviewed with patient.

02/26/20 Julis Fellows, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group Progress Note. CC: Patient presents for followup on pain in his bilateral hands. At last visit, he presented early due to a flare up of pain. Currently, he still reports increased pain right greater than left, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well primarily to the 4th and 5th digits of the right upper extremity. He reports improvement with acupuncture treatment and he has completed all of his approved sessions. He would like to continue this if possible. He started massage therapy and it did cause some increased pain. He will try to be more vocal with the therapist. He states that he underwent an MRI and upper extremity EMG through his QME 3 weeks ago. Dx: 1) Other soft tissue disorders related to use, overuse and pressure, left forearm. 2) Other soft tissue disorders related to use, overuse and pressure, right forearm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right upper arm. Tx Plan: Prescribed Voltaren 1% Gel. Will request for 6 additional sessions of acupuncture currently. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using

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upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

03/25/20 Julis Fellows, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group Progress Note. CC: Patient presents for followup on pain in his bilateral hands. At his last visit, he presented early due to a flare up of pain. Currently, he still reports increased pain, right greater than left, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity. He reports improvement with acupuncture treatment, and he has completed all of his approved sessions. He was approved for 12 more sessions but the facility is currently closed due to COVID 19. He will begin this when it is safe to proceed. He states that he attended 2/6 sessions of massage therapy but this caused a significant increase in pain. He did stop attending these for this reason. Do have his QME report from Dr. Stoller to review currently. Per him, he already underwent the recommended upper extremity EMG and some MRIs of his wrists. He has been using Voltaren gel for topical relief of his symptoms. However, he recently trialed lidocaine ointment instead and found this to be far more effective than Voltaren gel. He inquires about a prescription for this. Dx: 1) Other soft tissue disorders related to use, overuse and pressure, left forearm. 2) Other soft tissue disorders related to use, overuse and pressure, right forearm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right upper arm. Tx Plan: Prescribed Lidocaine 5% ointment. Will

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request for cervical MRI. Pending the results, will discuss the potential for epidural injections versus conservative treatment. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

04/01/20 Adam J. Stoller, MD –Remedy Medical Group Medical Legal Supplemental Report.

04/03/20 Jennifer Lin, MD - Simon Med Radiology/Diagnostics. MRI of Cervical Spine without Contrast. Indication: Pain. Impression: 1) Mild multilevel degenerative changes pf the cervical intervertebral discs and facets including a 4 mm left posterior lateral disc osteophyte complex at C5-C6 and 3 mm left paracentral extension at C6-C7 extending 2 mm superiorly and 2 mm inferiorly from the intervertebral disc level. 2) Moderate right C3-C4, severe bilateral C5-C6 neural foraminal narrowing. 3) Mild C5-C6 and C6-C7 central canal stenosis.

04/06/20 Adam J. Stoller, MD - Remedy Medical Group Medical Legal Supplemental Report.

04/24/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient is here to f/u on pain in his

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bilateral hands. He continues to report pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling." He continues to report numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He was approved for acupuncture treatment and he has had around 3 sessions so far. He had cervical MRI, do have this for review. EMG was done at his QME evaluation. He report improvement with topical medications. He requested refills. Dx: 1) Other soft tissue disorders related to use, overuse and pressure, left forearm. 2) Other soft tissue disorders related to use, overuse and pressure, right forearm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right upper arm. Tx Plan: Approved for additional acupuncture therapy and had around 3 sessions so far. Discontinued massage therapy due to increased pain. He did have QME with Dr. Stoller on 01/23/20. According to Dr. Stoller, patient is not MMI. Recommended upper extremity EMG and cervical spine MRI. Discussed possibility of CESI. He will take time to think about this and will consider requesting at subsequent f/u visits. Prescribed Voltaren gel and lidocaine cream. Consider trial of neuropathic medications in future. He prefers topical medications at this time. Work Status: Off work. Not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

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05/29/20 Jessica Aikin, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for followup on pain in his arms and bilateral hands. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He has numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He has recently completed 12 sessions of acupuncture treatment, with these sessions he reports a 30% reduction in pain complaints. This treatment allows him to be more active, and rely less on medications. He would be interested in continuing with this treatment. With regard to medication, he continues with Lidocaine cream and Voltaren gel as topical medications. He does request for refills currently. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. Tx Plan: Will request for 12 additional sessions of acupuncture treatment based on functional improvement as discussed. Discussed the possibility of CESI, he has thought about injections, and he has decided to defer at this time. He would he interested in a surgical consultation, will request for this currently with Dr. Paul Slosar. With regard to medication, Voltaren gel and Lidocaine cream refilled currently. He prefers topical medications at this time. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

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06/12/20 Jessica Aikin, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group Progress Note. CC: Patient is here to f/u on pain in his arms and bilateral hands. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He has numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. Since his most recent visit, he has been approved for 12 additional sessions of acupuncture treatment. Also have Dr. Bathia's BUE, EMG report from 02/10/20. The request for surgical consult for the neck was denied and will be appealed. With regard to medication, he continues with Lidocaine cream and Voltaren gel as topical medications. He denies side effects with his medications. He does not request for refills. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Massage therapy exacerbated his pain. He is not currently working. He did have a QME with Dr. Stoller on 01/23/20. Per Dr. Stoller, the he is not yet MMI. He recommends an upper extremity EMG to assess his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy, Cervical MRI was completed on 04/03/20 and is reviewed, EMG was completed on 02/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side. Requested for surgical consult for the

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bilateral elbows to address bilateral ulnar neuropathy, with Dr. Leonard Gordon. He has a QME re-evaluation with Dr. Stoller on 08/20/20. He has been approved for 12 additional sessions of acupuncture treatment. Will monitor his response. With regard to the cervical spine, MRI of the cervical spine from 04/03/20 shows a 4 mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. Discussed the possibility of CESI, he defers injections at this time. The request for surgical consultation with Dr. Paul Slosar was denied and will be appealed. No medications refilled at this visit. Work Status: Not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

06/23/20 Andreas Schwerte, LAc Patient participated in acupuncture therapy sessions from 11/05/19 to 06/23/20.

07/10/20 Jessica Aikin, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient was not physically able to come into the office due to compliance with the current National Emergency guidelines for the COVID-19 pandemic therefore a telemedicine followup visit was done currently. He presents for followup of pain in his arms and bilateral hands. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates

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Acupuncturist

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Neeti A. Bathia, M.D.
Musculoskeletal, Sports, Spine and Electrodiagnostic Medicine

George J. Rakkar, M.D.
Interventional and Chronic Pain Medicine

Alessandra A.E. Ross, M.D.
Orthopaedic Surgery, Sports Medicine

R. Elaine Lambert, M.D.
Rheumatologist

Marina Zyskina, N.P.

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from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports that pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He has been approved for a surgical consultation for the bilateral elbows with Dr. Leonard Gordon to discuss ulnar mononeuropathy at the bilateral elbows. This appointment is scheduled for 07/22/20. With acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. He would like to continue with this treatment modality. With regard to medication, he continues with lidocaine cream and Voltaren gel as topical medications. He does request for refills currently. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Patient was injured during the course of his usual and customary work. He has worked as an EKG technician and requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working. He did have a QME with Dr. Stoller on 01/23/20. Per Dr. Stoller, he is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 04/03/20 and is reviewed, EMG was completed on 02/10/20 with Dr. Neeti Bathia, and this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side. With regard to the bilateral elbows, he has been approved for a surgical consult to address bilateral

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ulnar neuropathy with Dr. Leonard Gordon. He is scheduled on 07/22/20. He has a QME re-evaluation with Dr. Stoller on 08/20/20. He continues with acupuncture treatment currently, with benefit. Will request for 12 additional sessions based on functional improvement as discussed. With regard to the cervical spine, MRI of the cervical spine from 04/03/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right, shoulder and deltoid pain. Discussed the possibility of CESI, he defers injections. Request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. He will continue to discuss this with his attorney. Refilled lidocaine cream and Voltaren gel. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing or pulling greater than 5 lbs. F/u in 4-6 weeks.

07/22/20 Leonard Gordon, MD - Hand and Microsurgery Medical Group, Inc Orthopaedic Hand Surgery Consultation. HPI: Patient states that on 02/15/19, he noted pain in his right hand and then the left, especially with use of the mouse. He made some ergonomic changes and moved to a pedal with no improvement. He was treated by Dr. Lane and taken off work, and he was diagnosed with a repetitive stress injury. He was sent for extensive therapy with no improvement, and he was assessed as permanent and stationary in 07/2019. He then was referred to Dr. Jamasbi and continued off work, and he had a QME by

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Dr. Stoller in 10/2019. An electrodiagnostic study was done, which showed ulnar neuropathy at both elbows and a question of a radiculopathy at C6-C7. Dr. Jamasbi sent him for acupuncture treatment with temporary relief. He was also sent for massage, and he states he is concerned that the massage in fact made him worse, especially on the right side. He presents at this time for surgical consultation. CC: Currently, patient has generalized pain in the extremities that is poorly localized. He does not have any specific symptoms at night. He has pain around the shoulder radiating distally. There are no localizing features. He states he does have a tremor in the hand. Dx: Repetitive Stress injury, right hand and repetitive stress injury left hand. Assessment: Patient appears to have repetitive stress as far as his right and left upper extremities are concerned. Can find no evidence for nerve entrapment despite the fact that the electrodiagnostic study at both elbows shows cubital tunnel syndrome. The provocative tests do not indicate that to be the case. Unable to confirm this, and there are no localizing features. Do not find any other problem, other than a nonspecific cumulative trauma in the extremities. There is a question of a nerve problem in the neck with a question of radiculopathy, although this radiculopathy was at the C6-C7 level and his symptoms of the cubital tunnel and ulnar side of the hand primarily would be C8-T1. That said, would leave it up to Dr. Jamasbi and a neck specialist to assess whether there are neck problems, although the extremity problems do not appear to arise from the neck. Do not feel, therefore, that there are any surgical options that would be helpful. If anything changes, would be pleased to reassess this.

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08/07/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for followup on pain in his arms and bilateral hands. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He did see Dr. Leonard Gordon on 07/22/20, regarding ulnar mononeuropathy at the bilateral elbows as seen on most recent EMG. Per him. Dr. Gordon feels that this may have been a misdiagnosis and he did not recommend surgery. Our request for 12 additional sessions of acupuncture treatment has been denied, according to him. Do not yet have this denial letter, but will review when made available so that can appeal. As previously discussed with acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. His pain is made worse with massage therapy. With regard to medication, he continues with Lidocaine and Voltaren gel as topical medications. He does request for refills currently. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soil tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Refilled Lidocaine 5% ointment and Voltaren 1% gel. With regard to the bilateral elbows he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 07/22/20. Per him, he is not being recommended for surgery.

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Will request for Dr. Gordon's report. He has a QMF re-evaluation with Dr. Stoller, which has currently been postponed until 01/2021. Per him, our recent request for 12 additional sessions of acupuncture has been denied. Will appeal this based on functional improvement as discussed. Discussed CESI, he defers injections. Request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Will re-request for surgical consultation for the neck currently as this was included in his QME. Will request for TPI in the bilateral trapezius region. Did discuss his work restrictions currently. He has significant pain in his arms with extended periods of typing and computer work, therefore have updated his work restrictions to reflect this currently. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift. Light computer work for up to an hour for an 8 hour shift. No lifting, pushing, or pulling greater than 5 lbs.

09/04/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for f/u on his arms and bilateral hands. He continues to report bilateral arm pain with pain in his bilateral upper extremities, right greater than left. Pain radiates from hands and wrist up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling." He reports pain in his neck as well as numbness and tingling in his 4th and 5th digits. Pain is worse with activity and better with conservative treatment. Request for 12 sessions of acupuncture was denied and is in process of appeal. In the meantime, he would be interested

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in trying aqua therapy. He continues with lidocaine and Voltaren gel and requested refills. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Prescribed gabapentin, Voltaren gel, and lidocaine. Regarding bilateral elbow, he was approved for a surgical consult and did see Dr. Leonard Gordon on 07/22/20. Per patient, he is not being recommended for surgery. Request Dr. Gordon's report as well as Dr. Liberty Jenkins new EMG report. His QME reevaluation with Dr. Stoller was postponed until 01/2021. His acupuncture therapy request was denied and recommended 6 sessions of aqua therapy for his wrists, hands, and elbows. MRI of his cervical spine from 04/03/20 showed a 4 mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. Discussed CESI, he defers injections. Request for surgical consultation with Dr. Paul Slosar was deferred on basis that his insurance is disputing liability for the body parts of the neck and bilateral upper arm. The recent re-request for surgical consultation for the neck, as well as TPI in bilateral trapezius region were deferred due to dispute of liability of the neck as part of his claim. Refilled lidocaine and Voltaren gel. Prescribed gabapentin at night and monitor his response at next visit, consider titrating up to full therapeutic dosing if tolerated. Work Status: Not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

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09/20/20 Adam J. Stoller, MD - ReMeDy Medical Group Medical Legal Supplemental Report.

09/25/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient presents for followup on pain in his arms and bilateral hands. He denies acute changes to his pain complaints currently. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He has been approved for 6 sessions of aqua therapy. With regard to medication, he continues with Lidocaine cream and Voltaren gel as topical medications. He denies side effects with his medications. He does request for refills currently. He took one tablet of gabapentin that was prescribed at his previous visit, and he reports extreme fatigue for days from this medication. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soil tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Refilled Lidocaine 5% ointment and Voltaren 1% gel. With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar

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neuropathy and did see Dr. Leonard Gordon on 07/22/20. Per him, he is not being recommended for surgery. Have requested for Dr. Gordon's report as well as Dr. Liberty Jenkins new EMG report. He has a QME re-evaluation with Dr. Stoller, which has currently been postponed until 01/2021. Request for 12 additional sessions acupuncture has been denied on appeal and submitted for IMR review, no updates currently. He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. Will monitor his response to this treatment. Discussed CESI, he defers injections. Request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim. With regard to his work restriction, have indicated that he can perform 1 hour of computer work in an 8 hour day, are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a coveted body part despite having an MRI of the cervical spine authorized. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift. Light computer work for up to an hour for an 8 hour shift. No lifting, pushing, or pulling greater than 5 lbs. F/u in 4-6 weeks.

11/06/20 Jessica Aikin, PA-C/Babak J. Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group PTP's Progress Report. CC: Patient was not physically able to

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come into the office due to compliance with the current National Emergency guidelines for the COVID-19 pandemic therefore a telemedicine followup visit was done currently. He presents via Facetime to follow up on pain in his arms and bilateral hands. He denies acute changes to his pain complaints. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists tip to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He has been approved for 6 sessions of aqua therapy, but these are currently on hold as no pool facility is open due to COVID-19. Previously, he had been attending acupuncture therapy with benefit hat additional sessions have been denied on appeal. He met with Dr. Gordon for a surgical consult on 07/22/20, reviewed. With regard to medication, he continues with lidocaine cream and Voltaren gel as topical medications. He does request for refills. He reports that a few months back he look gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. Due to the fatigue, he had some blood work done that showed elevated TSH. He attributes this elevation in TSH to his use of gabapentin and inquires about having this level repeated. This is discussed. Dx: 1) Cervical disc disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on

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07/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presence of ulnar neuropathy through physical exam despite it being present on his EMG. He reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presence of ulnar neuropathy. Did not have this report for review. Given that Dr. Gordon does not recommend a surgical intervention, will resubmit for acupuncture with a change in material facts with his report attached. He has been approved for 6 sessions of aqua therapy for his wrists, bands, and elbows these are currently on hold due to COVID-19. With regard to the cervical spine, MRI of the cervical spine from 04/03/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right, shoulder and deltoid pain. Discussed the possibility of CESI, he defers injections. Request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim. QME with Dr. Stoller has been postponed until 01/2021. With regard to his work restrictions, indicated that he can perform 1 hour of computer work in an 8 hour day, unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. He states that he was recently let go from his employer. With regard to medications, Voltaren gel and lidocaine ointment refilled. Gabapentin discontinued

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due to side effects. As mentioned, he has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had abnormal TSH shortly after discontinuing gabapentin and he believe that the medication is responsible for the abnormal level. Since he took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving however so will not be ordering a repeat level currently. Work Status: Patient is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. Light computer work for up to an hour for an 8 hour shift. No lifting, pushing or pulling greater than 5 lbs. F/u in 4-6 weeks.

IMPLICATIONS OF MEDICAL RECORD REVIEW:

The patient's PTP, Dr. Jamasbi, is appropriately treating the patient's radiculopathy, which may be responsible for more of the patient's symptoms than the carpal tunnel syndrome. Referral to a spine surgeon is a wise therapeutic decision. Bother the cervical radiculopathy and the carpal tunnel syndrome are medically likely to have resulted form Mr. Shockley's work with long hours mousing and in a suboptimal ergonomic position while doing this computer work.

The patient is not P and S. He should be seen 1 year after decompressive cervical surgery or when curative treatment options are exhausted.

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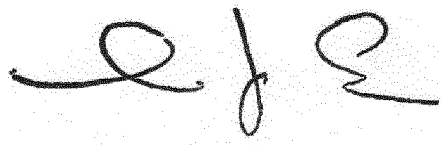
"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,



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CC: Mario Castro, Claims Adjuster
James Goines, Defense Attorney
Zachary Kweller, Applicant Attorney

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Name Jonathan Shockley 09/27/1978 Date 12/08/2020

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ APPEAL - 6 sessions of Acupunture for the Neck, Bilateral hands, wrist and forearm

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm , M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm ,
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region , G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Filip Cheng, D.O.
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January 23, 2020

PANEL QUALIFIED MEDICAL EVALUATION - ML-102

RE: SHOCKLEY, Jonathan
DOB: 09/27/1978
INSURANCE: Chubb Group Insurance Company
CLAIM #: 7173815490
DOI: 02/15/2019
EMPLOYER: CardioNet

Dear Concerned Parties:

Mr. Jonathan Shockley had an appointment for Remedy Medical Group at 01/23/20 on 490 Post Street, Suite 900, San Francisco, California 94102 from 1 p.m. to 2 p.m. I spent one hour face-to-face with the patient. Rosa Fesili assisted me with record review. A total of forty-five minutes were spent in record review. This will be billed as an ML-102.

HISTORY OF PRESENT ILLNESS:

Mr. Shockley is a right-handed EKG technician at CardioNet. His job is comprised of processing approximately thousand EKGs an hour, which involves about seven hours of day of sitting to work on the computer, extensive mouse clicking, and keyboarding. He has a history of hand and wrist pain in 2009 while he was teaching ballet. He saw a hand surgeon, Dr. Markison, who recalls that he has right-sided greater than left-sided tenosynovitis that resolved several weeks after its onset. He started working in June 2018 at CardioNet. He noticed initially that his right hand started hurting and he got a left-handed mouse in October 2018. He had no right hand improvement and then his left hand and forearm started hurting him. He got a pedal, so he could click with his foot in December 2018 and his foot started bothering him.

On 02/15/19, he had extreme pain in both hands and arms and reported it to his boss. He was sent to see Dr. Lang, who is a hand surgeon. The hand surgeon sent him to PT where they did an ultrasound and hot and cold therapy which did not help. He was not offered any injection or further therapies. He was made permanent and stationary and Dr. Jamasbi later saw him and did acupuncture, massage, and during the course of treatment of Dr. Jamasbi, he received some TENS therapy which he states caused a flare-up of his pain. He has not received TENS since that episode, but he reports that his pain on the right side still goes up into his right shoulder.

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CURRENT COMPLAINTS:

He reports bilateral arm aching and burning and bilateral neck aching. He states that his bilateral arm pain is constant and moderate in intensity and he has intermittent neck pain that is mild and he has arm numbness and tingling that is intermittent and mild. He also reports moderate loss of sexual functioning.

His neck pain ranges from 2 to 3 out of 10. His arm pain is currently between a 3 and a 4 out of 10. His pain is exacerbated by lifting, hand activity, writing, cleaning, and dressing. It is better with rest, acupuncture, and massage. Ibuprofen and diclofenac are also helpful in alleviating his pain. He has no problems with sitting, standing, or walking tolerance. Treatment for his current problem; He went to Golden Gate Hand Therapy for nine weeks twenty-five weeks ago. He had a 5% improvement. He had acupuncture with Andreas Schwerte for eight weeks, which improved his pain by 25%. He denies any problems with gait or loss of bladder or bowel control. The sports or activities he is unable to perform include ballet, chess teaching, house repairs, lifting heavy objects, cleaning, and/or cooking massage, sexual activities, and card playing.

His sleep is affected. It is hard to fall asleep when he has a flare of his pain. He gets six to seven hours of sleep a night. He has difficulty both falling asleep and staying asleep.

He states that a lot of activities are affected because he is unable to use his hands or his fingers.

His mood is affected. He has increased anxiety despair, which he is managing with medication.

His gastrointestinal system is not affected.

His functional limitations include not being able to write, use a computer or cell phone, difficulty with cooking, cleaning, lifting heavy objects, playing sports, house repairs and projects, teaching ballet or chess, firmly shaking hands. He cannot lift any more than 5 pounds.

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MEDICAL HISTORY:

1. Anxiety.

SURGICAL HISTORY:

1. Adenoidectomy.
2. LASIK surgery.
3. Sympathectomy.
4. Big toe bone spur removal.
5. Achilles tendon debridement.

SOCIAL HISTORY:

He is single. He does not consume any alcohol. He does not use any tobacco products.

FAMILY HISTORY:

Rheumatoid arthritis.

REVIEW OF SYSTEMS:

Fourteen-point review of systems is positive for the aforementioned problems, otherwise, negative.

OCCUPATIONAL HISTORY:

He worked as an EKG tech initially at BioTelemetry LifeWatch, started in June 2018. He was with this employer for a year. He was in the occupation for a year.

His previous employer was Pacific Chess Academy. He was with them for two years.

In the course of a normal workday, he states he was sitting for seven and a half hours. The demands that restrict him from regular duty are continuous computer work with mousing and keyboarding.

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He was satisfied with his job.

TREATING PROVIDERS:

1. Dr. Patrick Lang.
2. Dr. Babak Jamasbi.
3. Dr. Robert Markison.

CURRENT MEDICATIONS:

1. Advil, taking a total of 1600 mg a day.
2. Voltaren cream.
3. Aspirin 81 mg.

DRUG ALLERGIES:

He has no known drug allergies.

VALIDATED QUESTIONNAIRES:

1. PHQ-9 is 1/30, indicating no reactive depression.
2. Epworth Sleepiness Scale is 3, indicating no abnormal daytime somnolence.

QUESTIONS CONCERNING ACTIVITIES OF DAILY LIVING:

1. Self-care activities are uncomfortable and done slowly.
2. I can lift and carry heavy objects, but I get extra discomfort.
3. There has been no change in his ability to walk after the injury.
4. He states very heavy activity is the most strenuous level of activity he can do for at least two minutes.
5. He has no difficulty climbing a flight of stairs.
6. He can sit without any time limitation.
7. He can stand or walk between one to two hours at a time.
8. He has some difficulty with reaching and grasping for something off of a shelf at chest level.

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9. He has some difficulty reaching and grasping for something off of a shelf overhead.
10. He can push or pull heavy objects.
11. He has a lot of difficulty with griping, grasping, holding, and manipulating objects with his hands.
12. He has a lot of difficulty with repetitive motions such as typing on a computer.
13. He has a lot of difficulty with forceful activities with his arm and hands.
14. He has no difficulty with kneeling, bending, and squatting.
15. His sleep is moderately disturbed because of his injury.
16. There has been a moderate change in his sexual function due to his injury.
17. His pain is moderate at the moment.
18. His pain is moderate most of the time.
19. His pain and injury interfere with his ability to travel some of the time.
20. Most of the time, his pain and injury interfere with his ability to do daily chores.
21. Some or little of the time, his pain and injury interfere with his ability to engage in social activities.
22. A lot or most of the time, his pain and injury interfere with his ability to engage in recreational activities.
23. Some of the time, his pain and injury interfere with his ability to concentrate or think.
24. His pain and injury have caused mild depression or anxiety.
25. He believes that the following statements are true:
    a. I am afraid that if I exercise, I will hurt myself.
    b. My body is telling me I have something dangerously wrong.
26. There has been a severe change with his ability to communicate by typing and writing. There has been no change regarding communication by hearing, seeing, or speaking.
27. Regarding his ability to work, I cannot do my usual work and can hardly do any work at all.

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SPECIFIC WORK AND FUNCTIONAL CAPACITY ACTIVITY ESTIMATE BY THE PATIENT AT PRESENT TIME:

1. He can do six to eight hours of the following:
    a. Sitting.

2. He can do four to six hours of the following:
    a. Walking.

3. He can do two to four hours of the following:
    a. Bending and twisting at the waist.
    b. Kneeling.
    c. Climbing stairs.
    d. Walking over uneven ground.
    e. Squatting.
    f. Climbing ladders.

4. He can do less one to two hours of the following:
    a. Repetitive neck motions.
    b. Static neck posturing.

5. He can do less than one of the following:
    a. Repetitive use of the upper extremity.
    b. Gripping and grasping with my left hand.
    c. Pushing and pulling on the left.
    d. Fine manipulation with my left hand.
    e. Reaching at shoulder level on the left.
    f. Reaching above shoulder level on the left.
    g. Repetitive use of the right upper extremity.
    h. Gripping and grasping with the right hand.
    i. Fine manipulation with the right hand.
    j. Pushing and pulling on the right.
    k. Reaching at shoulder level on the right.
    l. Reaching above shoulder level on the right.

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6. He can do zero hours of the following:
    a. Forceful use of the left upper extremity.
    b. Forceful use of the right upper extremity.
    c. Lifting and carrying 5 pounds.

MEDICAL RECORD REVIEW:

3.1.2019 P. Lang, MD. Hand surgery consultation for bilateral hand, wrist, and forearm pain. Patient is a right handed electrocardiogram technician who reports several month history of worsening bilateral hand, wrist, and forearm pain. Physical exam: Tinel;s sign in ulnar nerve at the elbow is negative bilaterally, Finkelstein's test is negative bilaterally, Watson's test negative bilaterally, forearm compartments are soft and nontender. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: recommend occupational hand therapist on a repetitive strain protocol. Optimize computer workstation ergonomic and use dragon software, follow up 6-8 weeks.

3.18.2019, 3.20.2019, 3.25.2019, 3.27.2019, 4.1.2019, 4.3.2019, 4.8.2019, 4.10.2019, 4.15.2019, 4.17.2019, 4.22.2019, 4.24.2019, 5.3.2019, 5.10.2019, 5.15.2019, 5.22.2019, 5.29.2019 A. Ting, OT., C. Wong, OT. Occupational therapy for bilateral hands. Diagnosis: pain in left hand. Pain in the right hand.

4.16.2019 P. Lang, MD. Hand surgery follow up for bilateral upper extremities. Patient reports improvement, used to have pain and bilateral hand, wrist and forearm, symptoms continue to wax and wane relative duplicate or use. Diagnosis: bilateral upper extremity repetitive strain injury. Plan: patient made some adjustments to ergonomic workstation which provides some mild improvement of symptoms, will maintain work restrictions from computer use for the next six weeks, continue to work with occupational therapist call follow-up in six weeks. Work status: no computer youth.

5.28.2019 P. Lang, MD. Hand surgery follow-up for bilateral upper extremities. Patient symptoms remain unchanged. Patient did undergo a formal ergonomic evaluation of the computer workstation. The patient has been off of work for several weeks now and the group is persistent, patient reports he was on the phone and started having right wrist and forearm pain from simply holding the phone. Diagnosis: same. Plan: patient symptoms are classic for

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repetitive strain injury, recommend we designate him permanent stationary pheasant permanent work restriction of no computer use. No follow-up needed.

PHYSICAL EXAM:

General:

Well-nourished, well-developed gentleman, in no acute distress.

Cardiac:

His extremities are warm and well perfused.

Pulmonary:

He is breathing comfortably on room air.

HEENT:

He has moist mucous membranes. He has tenderness to palpation in his cervical paraspinal muscles. He has 90 degrees of rightward and leftward rotation. He has C-spine flexion of 80 degrees, extension 20 degrees. All extremes of motions of the C-spine cause him to have neck pain. Lateral bending is 10 degrees bilaterally with pain at 10 degrees.

Musculoskeletal:

Bilateral 5/5 grip strength, bilateral 5/5 first to second and first to fifth digit grip strength. 5/5 biceps and triceps strength. Shoulder forward flexion is 160 degrees bilaterally with extension 50 degrees bilateral. Shoulder abduction is 120 degrees bilateral and adduction is 20 degrees bilateral.

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Neuro:

He has negative Tinel's sign bilaterally at the carpal tunnel and negative Tinel's bilaterally at the cubital tunnel. He has 1/2 biceps reflexes, 0/2 triceps reflexes, and 0/2 brachioradialis reflexes. Sensation is normal in his upper and lower extremities to light touch.

Psych:

Regular speech, tone, and prosody. Logical thought process. Odd affect.

IMPRESSION:

1. Cervicalgia.
2. Bilateral forearm and hand pain.

DIAGNOSTIC STUDIES:

1. He requires a bilateral upper extremity nerve conduction study/EMG.
2. He requires a cervical spine MRI.

PERMANENT AND STATIONARY STATUS:

He is not permanent and stationary. He needs further diagnostic workup. Once that workup is done and the appropriate treatment is offered, he should then be examined for first permanent and stationary status.

CAUSATION:

100% causation is found to the 02/15/19 cumulative trauma injury.

APPORTIONMENT:

He does have a previous injury in his upper extremities. I would like to see documentation of this to appropriately apportion current injury and its role in his pain.

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WORK RESTRICTIONS:

He should lift no more than 5 pounds at the current time.

FUTURE CARE:

1. He requires medication for neuropathic pain, topical medications, and medications for myofascial pain.
2. He should continue to see Dr. Jamasbi for treatment.
3. He may require cervical epidural steroid injection.
4. He may require trigger point injections.
5. He requires twenty sessions of acupuncture.
6. He may require twelve sessions of physical therapy every six months for the next four years for flares.
7. He is an ideal candidate for a functional restoration program.

Thank you for allowing me to be your QME. Should you have any questions, please constitute them in a form of request for supplemental and I would be happy to address them.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,

Adam J. Stoller, M.D.

0123 27662624

CC: Mario Castro, Claims Adjuster
James Goines, Defense Attorney
Zachary Kweller, Applicant Attorney

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September 20, 2020

MEDICAL LEGAL SUPPLEMENTAL REPORT

RE: SHOCKLEY, Jonathan
DOB: 09/27/1978
INSURANCE: Chubb Group Insurance Company
CLAIM #: 7173815490
DOI: 02/15/2019
EMPLOYER: CardioNet

Dear Concerned Parties,

I am in receipt of a July 24, 2020 request for a supplemental report from Mr. Zachary Kweller in the matter of Mr. Jonathan Shockley. I have spent 45 minutes reviewing medical records and 30 minutes drafting editing this report. This will be billed as an ML 106 with 1 hour and 15 minutes being spent.

1. Body parts: Please make an express statement as to whether or not Mr. Shockley sustained an injury to the cervical spine and bilateral upper arms in connection with his excepted CT injury through 2/15/2019.

Mr. Shockley sustained an injury to the cervical musculature due to a cumulative trauma injury through 2/15/2019. This is caused by prolonged periods of neck flexion and rotation while in flexion due to his work position. There is no evidence that he has an injury to his cervical spine.

Mr. Shockley did sustain an injury to his bilateral upper arms due to his feeling of trauma injury through 2/15/2019. This is due to overuse and pressure when to the nerves running through the cubital tunnel with sustained periods of elbow flexion while the patient worked.

Both of these injuries arise out of an act of employment and during the course of employment.

2. TTD/work restrictions: Please clarify the work restrictions for Mr. Shockley considering the restrictions you provided, the restrictions by Dr. Jamasbi, and the restrictions by Dr. Lang.

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Mr. Shockley should not do any repetitive activities using upper extremities for longer than 1 hour in the ER shift. He should not be lifting pushing or pulling greater than 5 pounds. I presume Dr. Lang's restriction of no use of a computer is seemingly based on keyboarding and mousing. Mr. Shockley could certainly use a computer with a voice to text software and could use a keyboard and mouse for less than 1 hour in any 8-hour shift.

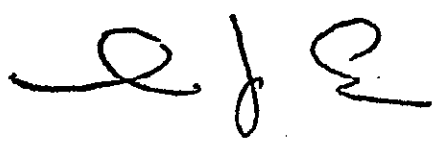
The applicant should have the above restrictions from 5/29/2019 on. I would consider this to be permanent work restrictions.

3. Records: Please review the records of Dr. Jamaal's be since her initial evaluation discussed whether any of these records changed any of the opinions outlined in your initial report or any supplemental reports.

Unfortunately, these records have been sent to us in a format that we do not have the capacity to process. I am happy to review the supplemental records when they are sent to format that my office is able to process (i.e., on paper not on CD-ROM).

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,



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Mark J. Sontag, M.D.
Sports, Spine and Electrodiagnostic Medicine

Elaine S. Date, M.D.
Musculoskeletal, Spine and Electrodiagnostic Medicine

Adam J. Stoller, M.D.
Interventional Pain Medicine

Mikel Davenport, L.A.c
Acupuncturist

REMEDY MEDICAL GROUP

Neeti A. Bathia, M.D.
Musculoskeletal, Sports, Spine and Electrodiagnostic Medicine

George J. Rakkar, M.D.
Interventional and Chronic Pain Medicine

Alessandra A.E. Ross, M.D.
Orthopaedic Surgery, Sports Medicine

R. Elaine Lambert, M.D.
Rheumatologist

Marina Zyskina, N.P.

www.remedydocs.com

Apr 06, 2020

MEDICAL LEGAL SUPPLEMENTAL REPORT - ML-106

RE: Shockley, Jonathan
EMP: CARDIONET LLC
DOI: 02/15/2019
CLAIM #: 7173815490

Dear Concerned Parties,

I am in receipt of a February 10, 2020, EMG/NCV of the bilateral upper extremities for Mr. Jonathan Shockly. I have spent 20 minutes reviewing this report, 20 minutes of reviewing her medical record and 20 minutes writing and editing this report. This will be billed as an ML-106 with 60 minutes spent.

This study is abnormal. There is evidence of bilateral demyelinating Ulnar mononeuropathy across the elbows. This is consistent with a diagnosis of bilateral cubital tunnel syndrome. He should continue to treat with Dr. Jamasbi. OT for his bilateral forearms with 14 sessions would be a good place to start treating this problem. If he fails to respond to HEP, OT, the use of elbow braces at night and medication, consultation with a surgeon may be appropriate.

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,

Adam J. Stoller, M.D.

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1900 O'Farrell Street, Suite 190
San Mateo, CA 94403
Telephone: 650.306.9490
Fax: 650.306.0250

San Francisco Office
490 Post Street, Suite 900
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Oakland Office
80 Grand Ave., Suite 810
Oakland, CA 94612
Telephone: 650.306.9490
Fax: 650.306.0205

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CC:
Mario Castro, Claims Adjuster
James Goines, Defense Attorney
Zachary Kweller, Applicant Attorney

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Pain & Rehabilitative
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Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Sep 25, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

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Patient is here via Facetime to follow up on pain in his arms and bilateral hands.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

He has been approved for 6 sessions of aqua therapy.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today. He took one tablet of gabapentin that was prescribed at his previous visit, and he reports extreme fatigue for days from this medication.

Medical History:

***

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

***

PSYCH/SOCIAL HISTORY

The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.

Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Gabapentin 300 Mg Capsule Take one QHS
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

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Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per the patient, he is not being recommended for surgery. We have requested for Dr. Gordon's report as well as Dr. Liberty Jenkins new EMG report.

- The patient has a QME re-evaluation with Dr. Stoller, which has now been postponed until January 2021.

- Our request for 12 additional sessions of acupuncture has been denied on appeal and submitted for IMR review, no updates today. He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. We will monitor his response to this treatment.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. Gabapentin discontinued due to side effects.

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Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.
*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a

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dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
6 Week(s)
with Julia Fellows, PA-C

CC:
Kweller, Esq., Zachary : 09/29/2020
Castro, Mario : 09/29/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 09/27/2020

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Sep 04, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamashi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:
***
Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

The patient did see Dr. Leonard Gordon on July 22, 2020, regarding ulnar mononeuropathy at the bilateral elbows as seen on most recent EMG. He has also had a new EMG of the bilateral upper extremities done with Dr. Liberty Jenkins, neurologist. Per the patient, this also confirmed ulnar neuropathy.

Our request for 12 sessions of acupuncture treatment was denied and is in the process of appeal. In the meantime, he would be interested in trying aqua therapy.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.

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The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of Aquatic Therapy (97113) Elbow Bilateral Elbows Wrist Bilateral Wrists Hand Bilateral Hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
1 Gabapentin 300 Mg Capsule SIG: Take one QHS QTY: 30.00.

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Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per the patient, he is not being recommended for surgery. We will request for Dr. Gordon's report as well as Dr. Liberty Jenkins new EMG report today.

- The patient has a QME re-evaluation with Dr. Stoller, which has now been postponed until January 2021.

- Our recent request for 12 additional sessions of acupuncture has been denied and will be appealed based on functional improvement that was documented at his last clinic visit. At this time we will request for 6 sessions of aqua therapy for his wrists, hands, and elbows.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. We will also trial Gabapentin, we will start him off with 300 mg at night and monitor his response at his next

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visit, consider titrating up to full therapeutic dosing if tolerated.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 25 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.
*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Gabapentin (Neurontin): The following has been recommended regarding Gabapentin (Neurontin) in the MTUS/ACOEM guidelines

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Anti-convulsant Agents for Neuropathic Pain
Recommended.

Anti-convulsants (Gabapentin, Pregabalin, Mirogabalin, Gabapentin Enacarbil, Lamotrigine, Topiramate, Carbamazepine, and Oxcarbazepine) are moderately recommended for treatment of neuropathic pain.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – High

Indications: Moderate to severe painful neuropathic pain sufficient neuropathic pain to require medication. Generally, anti-convulsants are considered a potential adjunct as a second- or third-line treatment for chronic neuropathic pain, after attempting other treatments (e.g., anti-depressants, aerobic exercise, other exercise).

Benefits: Modest pain reduction. May include reduced sleep disturbance.

Harms: Sedating properties may be intolerable. For some, the sedation is sufficient to impair daytime activities and thus, especially in those cases, be inappropriate for safety sensitive jobs. Also may have adverse effects including nausea, vomiting, dizziness, confusion, somnolence and weight gain.Carbamazepine may be associated with fluid and electrolyte abnormalities. Topiramate may cause kidney stones and ocular toxicity.

Frequency/Dose/Duration: Frequency and dosing are based on the medication prescribed. Duration of use for neuropathic pain patients may be indefinite, although many of these patients do not require indefinite treatment as the condition usually often resolves or improves. Gabapentin dose is initiated usually at 300mg/day and gradually raised.

Indications for Discontinuation: Resolution of pain, lack of efficacy, intolerance, or development of adverse effects. Monitoring of employed patients is indicated due to elevated risks for CNS-sedating adverse effects.

Rationale: There is high and moderate quality evidence of efficacy for multiple anti-convulsants (Gabapentin, Pregabalin, Lamotrigine, Carbazepime and Topiramate) for treatment of peripheral neuropathic pain in comparison with placebo [199][200, 201][191-194, 198, 202]. Although not all studies are positive [195, 196, 1146, 1147], the highest quality studies and those with larger sample sizes suggest efficacy. Nearly all quality evidence is of peripheral neuropathic pain, although at least one quality trial included MS patients [192]. There is not evidence that adding lamotrigine to gabapentin is efficacious [192]. Comparable efficacy has been suggested when comparing gabapentin and nortriptyline [1120]. In a study by Otto 2004, Valproic acid did not prove efficacious, however, in another study divalproex showed efficacy for post-herpetic neuralgia when compared to placebo at 8 weeks [1148]. Anti-convulsants are not invasive, have some adverse effects, are moderate cost, have some quality evidence of efficacy for treatment of neuropathic pain and are recommended.

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Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is high-quality and moderate-quality studies incorporated into this analysis. There is low-quality evidence listed in Appendix 4.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with

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references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 09/08/2020
Castro, Mario : 09/08/2020
UR, Chubb : 09/08/2020
UR, Chubb : 09/09/2020
Kweller, Esq., Zachary : 09/11/2020
Castro, Mario : 09/11/2020
UR, Chubb : 09/11/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 09/04/2020

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Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue

Emeryville, CA 94608

Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley 09/27/1978 Date 09/11/2020

Address 1000 Sutter St Room 123 San Francisco, CA 94109

Rx 6 sessions of Aquatic Therapy for the Bilateral Elbows, Bilateral Wrists and Bilateral Hands

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm, M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm, M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm, M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm, M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region, G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Robert J. Estis, P.A.
DEA#: ME0720513 / LIC#: PA12019

☐ Jessica Aikin, P.A.
DEA#: MA4725353 / LIC#: 51677

☐ Shohreh Semati, FNP-BC
DEA#: MS3193264 / LIC#: 18520

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POS Reorder # 1916761

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Aug 07, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:
***
Patient is here to follow up on pain in his arms and bilateral hands.

Patient denies acute changes to his pain today. continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

The patient did see Dr. Leonard Gordon on July 22, 2020, regarding ulnar mononeuropathy at the bilateral elbows as seen on most recent EMG. Per the patient, Dr. gordon feels that this may have been a misdiagnosis and he did not recommend surgery.

Our request for 12 additional sessions of acupuncture treatment has been denied, according to the patient. We do not yet have this denial letter, but will review when made available so that we can appeal. As previously discussed with acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. His pain is made worse with massage therapy.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

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FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Neck.

Trigger point injections to be done in office for the bilateral trapezius musculature.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:
***
Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per the patient, he is not being recommended for surgery. We will request for Dr. Gordon's report.

- The patient has a QME re-evaluation with Dr. Stoller, which has now been postponed until January 2021.

- Per the patient, our recent request for 12 additional sessions of acupuncture has been denied.

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We will appeal this based on functional improvement as discussed above.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. We will re-request for surgical consultation for the neck today as this was included in his QME.

- We will request for TPI in the bilateral trapezius region.

- We did discuss his work restrictions today. He has significant pain in his arms with extended periods of typing and computer work, therefore we have updated his work restrictions to reflect this today.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

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Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches

for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating

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physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 08/11/2020
Castro, Mario : 08/11/2020
UR, Chubb : 08/12/2020
Kweller, Esq., Zachary : 08/13/2020
Castro, Mario : 08/13/2020
UR, Chubb : 08/13/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 08/07/2020

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Jul 10, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

He has been approved for a surgical consultation for the bilateral elbows with Dr. Leonard Gordon to discuss ulnar mononeuropathy at the bilateral elbows. This appointment is scheduled for July 22, 2020.

With acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. He would like to continue with this treatment modality.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

Medical History:

PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.

The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
for bilateral hands, wrists, and forearms.

12 sessions of acupuncture 97813, 97814, 97026, 97124.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

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Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he has been approved for a surgical consult to address bilateral ulnar neuropathy with Dr. Leonard Gordon. He is scheduled on 7/22/20.

- The patient has a QME re-evaluation with Dr. Stoller on August 20, 2020.

- The patient continues with acupuncture treatment at this time, with benefit. We will request for 12 additional sessions based on functional improvement as discussed above.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed the possibility of CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. He will continue to discuss this with his attorney.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today.

Follow up in 4-6 weeks.

WORK STATUS:

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WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

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Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup,

2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 07/13/2020
Castro, Mario : 07/13/2020
Kweller, Esq., Zachary : 07/14/2020
Castro, Mario : 07/14/2020
UR, Chubb : 07/14/2020

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This visit note has been electronically signed off by Aikin, Jessica, PA-C on 07/10/2020

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Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley Date 07/14/2020

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ 12 sessions of Acupuncture for the bilateral hands, wrists, and forearms

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Robert J. Estis, P.A.
DEA#: ME0720513 / LIC#: PA12019

☐ Jessica Aikin, P.A.
DEA#: MA4725353 / LIC#: 51677

☐ Shohreh Semati, FNP-BC
DEA#: MS3193264 / LIC#: 18520

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POS Reorder # 1916761

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Jun 12, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamashi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He has numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Since his most recent visit, he has been approved for 12 additional sessions of acupuncture treatment. We also have Dr. Bathia's BUE EMG report from 2/10/20. Our request for surgical consult for the neck was denied and will be appealed.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does not request for refills today.

Medical History:

PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.

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Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Bilateral Elbows- with Dr. Leonard Gordon for bilateral ulnar neuropathy on EMG as requested by QME Dr. Stoller.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

TREATMENT PLAN:

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

Plan:

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- The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side. We will request for surgical consult for the bilateral elbows today to address bilateral ulnar neuropathy, with Dr. Leonard Gordon.

- The patient has a QME re-evaluation with Dr. Stoller on August 20, 2020.

- The patient has been approved for 12 additional sessions of acupuncture treatment. We will monitor his response.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed the possibility of CESI, the patient defers injections at this time. Our request for surgical consultation with Dr. Paul Slosar was denied and will be appealed.

-No medications refilled at this visit.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of

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accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 06/19/2020
Castro, Mario : 06/19/2020
UR, Chubb : 06/19/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 06/18/2020

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: May 29, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamashi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He has numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient has recently completed 12 sessions of acupuncture treatment, with these sessions he reports a 30% reduction in pain complaints. This treatment allows him to be more active, and rely less on medications. He would be interested in continuing with this treatment.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Neck- with Dr. Paul Slosar.

12- bilateral arms sessions of acupuncture 97813, 97814, 97026, 97124.

This is a formal request for authorization of the medications within the "prescriptions" section of

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this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm

TREATMENT PLAN:

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. He is not currently working. Massage therapy exacerbated his pain.

Plan:

- We will request for 12 additional sessions of acupuncture treatment based on functional improvement as discussed above.

- The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. This was completed on 2/10/20 with Dr. Bathia. We will request for her report.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be attributing to right shoulder and deltoid pain. We discussed the possibility of CESI, the patient has thought about injections, and he has decided to defer at this time. He would be interested in a surgical consultation, we will request for this today with Dr. Paul Slosar.

-With regard to medication, Voltaren gel and Lidocaine cream refilled today. The patient prefers topical medications at this time.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

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JUSTIFICATION:
Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the

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treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 06/03/2020
Castro, Mario : 06/03/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 06/01/2020

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Apr 24, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". he continues to report numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

He was approved for acupuncture treatment, he has had around 3 sessions so far.

He had a cervical MRI, we do have this for review. EMG was done at his QME evaluation, we do not have this report.

With regard to medications, he does report improvement with topical medications. He denies side effects with Lidocaine cream and voltaren gel. He requests for refills today.

Medical History:

PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.

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Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

PRESCRIPTION:
1 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00. REF: 1
2 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.

TREATMENT PLAN:

Assessment:

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This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. He is not currently working.

Plan:

- He has been approved for additional acupuncture therapy, he has had around 3 session so far. He has discontinued massage therapy due to increased in pain.

- The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. The patient states that he did have the upper extremity EMG at that evaluation, we will work on obtaining a copy of this report.

- MRI of the cervical spine from 4/3/20 was reviewed today with the patient. This shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral NF stenosis at C5-C6 may be attributing to right shoulder and deltoid pain. We discussed the possibility of CESI, the patient will take some time to think about this and we will consider requesting at subsequent follow up visits.

-With regard to medication, we have prescribed Voltaren gel and 5% lidocaine ointment. Will consider trial of neuropathic medications in the future, the patient prefers topical medications at this time.

Follow up in 4-6 weeks.

100% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. Fifteen minutes were spent in direct contact via telemedicine with the patient.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:

Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct contact via telemedicine with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under

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penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup,

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2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 04/27/2020
Castro, Mario : 04/27/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 04/27/2020

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Mar 25, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

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SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

At his last visit, he presented early due to a flare up of pain. Today he still reports increased pain, R>L, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity.

He reports improvement with acupuncture treatment, and he has completed all of his approved sessions. He was approved for 12 more sessions but the facility is currently closed due to COVID 19. He will begin this when it is safe to proceed.

Patient states that he attended 2/6 sessions of massage therapy but this caused a signficant increase in pain. He did stop attending these for this reason.

We do have the patient's QME report from Dr. Stoller to review today. Per the patient, he already underwent the recommended upper extremity EMG and some MRIs of his wrists.

Patient has been using Voltaren gel for topical relief of his symptoms. However, he recently trialed lidocaine ointment instead and found this to be far more effective than Voltaren gel. He inquires about a prescription for this.

OBJECTIVE FINDINGS:
Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed.
Orientation:
Patient is alert and oriented x3.
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Voltaren 1% Gel Apply 2-3 grams to affected area up to 4 times daily update amount
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Cervical Spine MRI without contrast (72141).

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm

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M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

PRESCRIPTION:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.

Changed/Discontinued Medication(s):
Discontinued: VOLTAREN 1% GEL - patient had better benefit from lidocaine

TREATMENT PLAN:

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

On exam he has full ROM of the bilateral shoulders with some discomfort. His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbow.

He has been approved for additional acupuncture therapy, but this is on hold due to COVID 19. He has discontinued massage therapy due to increased in pain.

We reviewed his QME with Dr. Stoller today. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. The patient states that he did have the upper extremity EMG done and we will try to obtain this report. He has not heard anything regarding the cervical MRI therefore we will request for this today. Pending the results, we will discuss the potential for epidural injections vs conservative treatment.

We will trial the patient on 5% lidocaine ointment today and monitor his progress.

Follow up in 4-6 weeks.

100% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. Fifteen minutes were spent in direct contact via telemedicine with the patient.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

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Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment

recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative

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Consultants Medical Group.

JUSTIFICATION:

MRIs - Cervical Spine Part 1: Following has been recommended by the MTUS/ACOEM Guidelines regarding Magnetic Resonance Imaging of the cervical spine

Magnetic resonance imaging (MRI) is considered the gold standard in diagnostic imaging for defining soft tissue anatomy due to its greater ability to distinguish soft tissues.(340-343) Thus, MRI is recommended to assess potential nerve root or spinal cord compression, if the patient is a candidate for surgery or radiation therapy, and if no contraindications to MRI exist. Computerized tomography (CT) remains an important analytical tool especially for evaluating bony or calcified structures.(340, 341, 344, 345) MRI may also be useful in the acute trauma setting to evaluate for soft tissue injury in non-communicative patients with a high pre-test probability of significant injury that would need intervention.(340, 344, 345) MRI also can determine if a fracture seen on x-ray is recent (still has marrow edema) or remote (healed and without marrow edema).

MRI for Diagnosing Red Flag Conditions

Recommended. MRI is recommended for patients with:

1. Acute cervical pain with progressive neurologic deficit;
2. Significant trauma with no improvement in significantly painful or debilitating symptoms;
3. A history of neoplasia (cancer);
4. Multiple neurological abnormalities that span more than one neurological root level;(340, 344-347)
5. Previous neck surgery with increasing neurologic symptoms;
6. Fever with severe cervical pain; or
7. Symptoms or signs of myelopathy.

Strength of Evidence – Recommended, Evidence (C)
Level of Confidence – High

Benefits: Diagnosis of a surgically treatable condition or otherwise latent medical condition(s).

Harms: Medicalization or worsening of otherwise benign spine condition.

Rationale: MRI has been evaluated in quality studies (see evidence table); however, most cases of cervicothoracic pain and radicular pain syndromes spontaneously resolve and require no imaging.(349-351) The sensitivity and specificity of MRI or CT are difficult to define as they require a "gold standard" that is difficult to define in spine pain since the final diagnosis often is based on the same imaging modality being tested. Therefore, these clinical studies may be prone to incorporation bias, artificially inflating the sensitivity and specificity with some assuming MRI has 100% sensitivity and specificity. Multiple case series have been reported in patients with acute cervicothoracic trauma with neurologic deficits. A retrospective review evaluated MR and

CT scans in 113 acute spine trauma patients. The study reported on a total of 166 lesions found on MRI and CT scan. MRI was reported to be superior to CT scan in finding soft tissue injury, ligamentous injury, high-grade stenosis, and spinal cord injuries.(347) A case series evaluated MRI and CT scans in 14 spinal trauma patients. They reported that CT missed 3 epidural hemorrhages (100%) found on MRI, and CT missed 3 of 5 (60%) intervertebral disc injuries found on MRI.(345) It has been shown that MRI is superior to CT scan and x-ray at identifying spinal cord injury and other soft tissue injuries.(340, 344-347, 352, 353)

A study evaluating 52 cervical radiculopathy patients with or without myelopathy reported that MRI was in agreement with the surgical findings 74% of the time. When MRI and CT myelography were conducted on the same patient, the radiographic diagnosis was in agreement with the surgical diagnosis 90% of the time.(343)

A study with 497 asymptomatic patients was conducted. An overall increase of MRI findings related to age ($p < 0.0001$) was reported. Grade 1 or Grade 2 disc degeneration was found in 17% of the discs in asymptomatic men and 12% of the discs in asymptomatic women in their twenties rising to 86% and 89%, respectively, in subjects over 60 years of age.(354) A study evaluated MRI findings in a cohort of high school students with or without cervicothoracic pain. They initially surveyed students about symptoms while they were in high school. Seven years after the first survey was completed another survey was done. The participants with cervicothoracic and shoulder pain on both occasions but without significant changes over the years were chosen as the symptomatic group.

Participants without cervicothoracic or shoulder pain at both survey times were the asymptomatic group. Participants had an MRI done at the end of the 7 years follow-up. Pathological changes of the cervical spine seen with MRI in 24 to 27 years old were reported to be equally common in the symptomatic and asymptomatic groups; 20 degenerated discs in the symptomatic group (SG) and 26 in the asymptomatic group (AG); 14 annular tears in the SG, 18 in the AG; 18 disc protrusions in the SG, and 29 in the AG. Disc herniations were the only finding more prevalent in the symptomatic group, 4 in the symptomatic group and 0 in the asymptomatic group.(355).

A prospective study evaluated MRI scans in acute whiplash patients at baseline and after 3 months. Each patient was involved in a RCT evaluating immobilization, active mobilization and advice to act as usual. The initial MRIs were performed on 178 patients and follow up MRIs on 82 (46.1%) patients. The most frequent finding was pre-existing degeneration 139/178 (78%). Bulges or protrusions of one or more discs were present in 35/178 (20%) of the participants. It was determined that 7 had findings on MRI that were "traumatic" in nature (paravertebral bleeding/edema, prevertebral bleeding/edema, edema in the spinal cord, or "traumatic" disc protrusion or bulge). The authors concluded that MRI is not the answer to a diagnosis in the vast majority of patients developing long-lasting pain after a whiplash injury, and early MRI scans do not predict prognosis.(356) Others have reported evidence of fatty infiltrates in the craniocervical flexors being statistically higher on MRI in those with chronic whiplash disorders.(353) However, a prospective, 10-year study has reported MRI findings do not explain persistent symptoms.(357)

Another study evaluated MRI findings in relation to the transverse ligaments of the atlas (alar ligaments). The study evaluated 92 whiplash-injured patients diagnosed as Grade 2 whiplash patients and 30 uninjured individuals who underwent proton density-weighted MRI of the craniovertebral junction at least 2 years after the injury. Twenty out of 117 (17.1%) had Grade 2 or 3 posterior atlanto-occipital membrane lesions. No Grade 3 lesions and only one Grade 2 lesion was found in the uninjured individuals. However, no clinical correlation was made in regard to prognosis or symptoms based in the MRI findings.(358) In another study using the same populations it was reported that the transverse ligament was classified as abnormal in 64% in the injured group and 27% of the uninjured group.(358) The authors failed to explain why the alar ligament should show signs of acute injury (increased signal) 2 to 9 years after the whiplash event in spines that are not clinically unstable. Other investigators did not find MRI evaluation of the alar ligaments clinically helpful due to the high prevalence of "abnormalities" in normal people.(359, 360)

There is no quality evidence for use of MRI within the first 6 weeks of symptom onset. However, rare cases are thought to need MRI and emergent/urgent surgery (see below).(343) Patients presenting with a mild single nerve root deficit, such as an absent deep tendon reflex, should not have early MRI, as their condition usually resolves spontaneously; thus, the test does not alter the course of treatment. Those who have a documented neurologic status that then objectively deteriorates (particularly a significant increase in weakness or an increased loss of sensation compared with the prior examination) and those with a history of cancer with symptoms suggesting atypical radicular presentation do have an indication for early imaging with MRI.

In the absence of red flags suggesting fracture or serious systemic illness, imaging before 6 weeks produces no clear health outcomes benefit.(355, 356, 361-364) Early imaging would be expected to result in higher overall costs and increased morbidity through the performance of some unnecessary procedures and/or surgeries. Disc degeneration, disc bulging, and endplate changes on MRI have been shown to either not correlate at all or correlate poorly with clinical outcomes, suggesting that MRI is not useful for most patients.(340, 341, 354-356)
Patients should be a priori informed that their MRI is highly unlikely to be "normal" as few patients have a normal MRI(354), and there is a considerable rate of resolution of herniations over 6 weeks after an initial MRI documented in the lumbar spine (see Low Back Disorders guideline). A patient handout describing the prevalence of "abnormal findings" on MRI of asymptomatic individuals is helpful. Physicians lacking the time or knowledge to explain these facts to patients should avoid ordering MRIs. The discovery of degenerative changes or clinically irrelevant disc herniations in many patients may cause them to focus on the need to "fix" MRI changes that are actually normal for their age or are asymptomatic findings.(354) This may also become a rationale for avoiding participation in the therapeutic activities that promote functional recovery. In addition, lack of understanding of the strengths, indications, and limitations of a technology preclude adequate clinical interpretation of the results. In those cases, consultation with a physician experienced in treating musculoskeletal disorders may be helpful.
A prospective, observational study using MRI preoperatively to predict postoperative recovery in 57 cervical spondylotic myelopathy (CSM) patients found MRI beneficial in predicting outcomes. The study found those with high T2SI and spinal cord failure were found to predict poorer recovery. Patients with low T1SI were predictive of greater impairment, and those with

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focal T2SI made more significant improvements in walking. However, the evidence of prognostic power for CSM patients is inconsistent.(365)

Open MRIs have lower ability to discern soft tissue without lower costs and are not recommended other than in circumstances where the patient is either morbidly obese and exceeds the closed MRI unit's weight specifications, or suffers from claustrophobia that is not alleviated with a low-dose anxiolytic administered prior to the procedure.

MRI is minimally invasive even when contrast is used, has few adverse effects, but is high cost. MRI changes treatment if it detects unrecognized fracture, systemic disease, or a spinal condition for which surgery is the recommended treatment.

Evidence: There are 3 high-quality studies (341, 366, 367) and 15 moderate-quality studies (340, 343-347, 352, 354-356, 358, 368-371) incorporated into this analysis.
A comprehensive literature search was conducted using multiple search engines including PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: magnetic resonance imaging, MRI, MRI scan, cervicalgia, neck pain, cervical pain, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular pain, intervertebral disc displacement, herniated, herniat*, displacement, displacements, displaced, disk, disc, disks, discs, pain, diagnostic, efficacy, efficiency, sensitivity, specificity, predictive value of tests, positive predictive value and negative predictive value. In PubMed, we found and reviewed 2,442 articles, and considered 8 for inclusion. In Scopus, we found and reviewed 186 articles, and considered 1 for inclusion. In CINAHL, we found and reviewed 68 articles, and considered zero for inclusion. In Cochrane Library, we found and reviewed 78 articles, and considered zero for inclusion. We also considered for inclusion 11 articles from other sources. Of the 25 articles considered for inclusion, 17 studies and 8 systematic studies met the inclusion criteria.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are

8558 107 20201124 13 :01

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generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:

Kweller, Esq., Zachary : 03/31/2020
Castro, Mario : 03/31/2020
Kweller, Esq., Zachary : 04/01/2020
Castro, Mario : 04/01/2020
UR, Chubb : 04/01/2020

This visit note has been electronically signed off by Fellows, Julia, PA-C on 03/25/2020

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Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name **Jonathan Shockley** Date **04/01/2020**

Address **1000 Sutter St Room 123** **San Francisco, CA 94109**

℞

Cervical Spine MRI without contrast

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

Refill

☐ Do Not Substitute

M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Robert J. Estis, P.A.
DEA#: ME0720513 / LIC#: PA12019

☐ Jessica Aikin, P.A.
DEA#: MA4725353 / LIC#: 51677

☐ Shohreh Semati, FNP-BC
DEA#: MS3193264 / LIC#: 18520

POS Reorder # 1916761

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note - SF (San Francisco) Appointment

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Feb 26, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:

Patient is here to follow up on pain in his bilateral hands.

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At his last visit, he presented early due to a flare up of pain. Today he still reports increased pain, R>L, radiating from his hand/wrist to his elbow and then up to his right shoulder. He describes this pain as burning and almost like a pulling sensation. He does report numbness and tingling as well, primarily to the 4th and 5th digits of the right upper extremity.

He reports improvement with acupuncture treatment, and he has completed all of his approved sessions. He would like to continue this if possible. He started massage therapy and it did cause some increased pain. He will try to be more vocal with the therapist.

The patient states that he underwent a MRI and upper extremity EMG through his QME 3 weeks ago. We do not have this report for review.

ROS:
Constitutional:
Patient denies chills, fever, night sweats, or severe fatigue.
Head:
Patient denies dizziness or headaches.
Eyes:
Patient denies wearing corrective lenses, blurry vision, or double vision.
Neck:
Patient complains of pain but denies lumps in his neck.
Respiratory:
Patient denies difficulty breathing, cough, coughing up blood, or wheezing.
Cardiovascular:
Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.
Gastrointestinal:
Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.
Genitourinary:
Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.
Skin:
Patient denies itching of skin, rash, or yellowing of skin.
Neurologic:
Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.
Hematologic:
Patient denies excessive bleeding or blood clots.
Psychiatric:
Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

Medical History:

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed.
Orientation:
Patient is alert and oriented x3.
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.
Gait and Station:
No abnormalities observed.
Musculoskeletal - Strength:
RUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5

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Digit Abduction 5/5.
LUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5
Digit Abduction 5/5.
Skin:
No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:
1. Voltaren 1% Gel Apply to affected area daily
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
12 sessions of acupuncture 97813, 97814, 97026, 97124 Bilateral hands, wrists and forearms.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

PRESCRIPTION:
1 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 100.00. REF: 1 update amount

Changed/Discontinued Medication(s):
Changed: VOLTAREN 1% GEL - update amount

TREATMENT PLAN:

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

8558 116 20201124 13 :01

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On exam he has full ROM of the bilateral shoulders with some discomfort. His motor exam for the elbows and hands were WNL. However, he did have a positive Tinel's at both elbow.

We will request for 6 additional sessions of acupuncture today.

He underwent a QME on Jan 23, 2020 and the patient had a MRI and EMG through this QME. We will review this when available.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(c) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under

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fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Acupuncture - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Acupuncture

Acupuncture
Acupuncture has been used to treat CTS and other hand, wrist, and forearm MSDs.(790, 791) There is evidence of its efficacy for treatment of chronic spine disorders, although the evidence suggests traditional acupuncture is not superior to other acupuncture methods (see Chronic Pain and Low Back Disorders Guidelines).

Acupuncture for Acute, Subacute, or Chronic CTS
Not Recommended. Acupuncture is not recommended for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – Not Recommended, Evidence (C)
Level of Confidence – Low

Rationale: There are quality trials of acupuncture compared with placebo or sham acupuncture and they have failed to show benefit of acupuncture for treatment of CTS.(792) One trial found no differences between acupuncture and oral steroid.(793, 794) Another trial susceptible to contact time bias found minimal differences between acupuncture and nocturnal wrist splinting.(781) Thus, the highest quality evidence suggests acupuncture is ineffective for treatment of CTS and acupuncture is not recommended.

Evidence: There are 4 moderate-quality RCTs incorporated into this analysis.(781, 792-794) There are 3 low-quality RCTs in Appendix 2.(795-797)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and

Cochrane Library without date limits using the following terms: Acupuncture, Acupuncture Therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random,* randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 40 articles in PubMed, 411 in Scopus, 83 in CINAHL, 46 in Cochrane Library and 0 in other sources. We considered for inclusion 7 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to

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prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

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CC:
Kweller, Esq., Zachary : 03/04/2020
Castro, Mario : 03/04/2020
UR, Chubb : 03/04/2020

This visit note has been electronically signed off by Fellows, Julia, PA-C on 03/02/2020

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Pain and Rehabilitative Consultants Medical G

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name **Jonathan Shockley** Date **03**

Address **1000 Sutter St Room 123** **San Francisco, CA 9410**

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12 sessions of Acupuncture for the Bilateral hands, wrists and forearms

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

Refill	

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. (
DEA#: M

☐ Julia M. F
DEA#: M

☐ Robert J. I
DEA#: M

☐ Jessica Ai
DEA#: M

☐ Shohreh S
DEA#: M

From bgenova 1.888.977.2986 Wed Mar 4 10:36:47 2020 EST Page 12 of 12

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note - SF (San Francisco) Appointment

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Jan 10, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year 3 Month 1 Week
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:
Patient is here to follow up on pain in his bilateral hands.

Patient denies acute changes to his pain complaints. He continues to report bilateral hand and arm pain, right greater than left. Occasionally pain radiates up from his hands into his bilateral

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forearms and up towards his neck. Pain is worse with repetitive use of his upper extremities, typing, or computer work. Pain is better with conservative treatment.

He reports improvement with acupuncture treatment, he has recently been approved for 6 additional sessions. With regard to massage therapy, he reports that this did not really help as the practitioner was only able to focus on his hands, while it's really his whole arms that are painful to him. He would be interested in continuing with this treatment if it were to include both arms rather than just both hands.

With regard to medication, he reports improvement with the use of Voltaren gel. He denies side effects with the use of this medication. He requests for a refill today.

ROS:
Constitutional:
Patient denies chills, fever, night sweats, or severe fatigue.
Head:
Patient denies dizziness or headaches.
Eyes:
Patient denies wearing corrective lenses, blurry vision, or double vision.
Neck:
Patient complains of pain but denies lumps in his neck.
Respiratory:
Patient denies difficulty breathing, cough, coughing up blood, or wheezing.
Cardiovascular:
Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.
Gastrointestinal:
Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.
Genitourinary:
Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.
Skin:
Patient denies itching of skin, rash, or yellowing of skin.
Neurologic:
Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.
Hematologic:
Patient denies excessive bleeding or blood clots.
Psychiatric:
Patient denies anxiety, depression, hallucinations, or suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

Medical History:

PAST MEDICAL HISTORY

8558 126 20201124 13 :01

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1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:

PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed.
Orientation:
Patient is alert and oriented x3.
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.
Gait and Station:
No abnormalities observed.
Musculoskeletal - Strength:
RUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5

8558 127 20201124 13 :01

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Digit Abduction 5/5.
LUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5
Digit Abduction 5/5.
Skin:
No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:
1. Voltaren 1% Gel Apply to affected area daily
2. Advil (OTC)
3. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:

6 sessions of Massage Therapy (97124)- for the bilateral upper extremies.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

PRESCRIPTION:
1 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

He is off work at this time.

8558 128 20201124 13 :01

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Plan:
- He has been approved for 6 additional sessions of acupuncture treatment, we will monitor his response to this.
- We will request for 6 sessions of massage therapy for his bilateral arms, rather than just his bilateral hands.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated. He continues to be off work.
- Voltaren gel refilled today.
- He is scheduled for QME on Jan 23, 2020. We will review this report when available.

Follow up in 4-6 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.
*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

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JUSTIFICATION:
Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects

8558 130 20201124 13 :01

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of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 02/03/2020
Castro, Mario : 02/03/2020
UR, Chubb : 02/03/2020
Kweller, Esq., Zachary : 02/03/2020
Castro, Mario : 02/03/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 01/31/2020

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

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Visit Note - SF (San Francisco) Appointment

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Nov 22, 2019
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year 1 Month 3 Week
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley came to our office today for a follow-up visit.

SUBJECTIVE COMPLAINTS:
Patient is here to follow up on pain in his bilateral hands.

He continues to report bilateral hand pain, right greater than left. Occasionally pain radiates up his arms towards his neck. Pain is worse with repetitive use of his upper extremities, excessive

8558 134 20201124 13 :01

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typing or computer work. Pain is better with conservative treatment.

He reports having a pain flair with the use of massage therapy, this dramatically increased his pain.

He also has been going to acupuncture treatment. This does help with his pain.

With regard to medication, he does take Advil as needed for pain.

ROS:
Constitutional:
Patient denies chills, fever, night sweats, or severe fatigue.
Head:
Patient denies dizziness or headaches.
Eyes:
Patient denies wearing corrective lenses, blurry vision, or double vision.
Neck:
Patient complains of pain but denies lumps in his neck.
Respiratory:
Patient denies difficulty breathing, cough, coughing up blood, or wheezing.
Cardiovascular:
Patient denies difficulty breathing while lying flat, fainting, abnormal heartbeat, or chest pain.
Gastrointestinal:
Patient denies constipation, heartburn, nausea, abdominal pain, black tarry stools, or throwing up blood.
Genitourinary:
Patient denies urinary incontinence, blood in urine, difficulty urinating, or painful urination.
Skin:
Patient denies itching of skin, rash, or yellowing of skin.
Neurologic:
Patient denies balance problems, poor concentration, memory loss, numbness, seizures, tremors, or weakness.
Hematologic:
Patient denies excessive bleeding or blood clots.
Psychiatric:
Patient complains of anxiety but denies depression, hallucinations and suicidal thoughts.

I have reviewed the review of systems with the patient and it is accurate as listed.

OBJECTIVE FINDINGS:
Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed.
Orientation:
Patient is alert and oriented x3.
Mood and Affect:

8558 135 20201124 13 :01

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Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Gait and Station:
No abnormalities observed.

Musculoskeletal - Strength:
RUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5
Digit Abduction 5/5.
LUE:
Arm Abduction 5/5
Forearm Flexion 5/5
Forearm Extension 5/5
Wrist Extension 5/5
Thumb Apposition 5/5
Digit Abduction 5/5.

Skin:
No rashes, lesions, café-au-lait spots, or ulcers observed on right upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left upper extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on right lower extremity.
No rashes, lesions, café-au-lait spots, or ulcers observed on left lower extremity.

Current Medications:
1. Advil (OTC)
2. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of acupuncture 97813, 97814, 97026, 97124 Hand Bilateral Hands.

DIAGNOSIS:
Z79.899 Other long term (current) drug therapy

PRESCRIPTION:
1 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:

Assessment:
during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hand. He has to click frequently. He started developing pain in his right hand and switched to the left.

8558 136 20201124 13 :01

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Plan:
- He will continue with acupuncture treatment, he has approximately 7 appointments remaining. Before acupuncture treatment his pain is a an 4-6/10, this will decrease down to approximately down to a 2-3/10, this allows him to use his hands more. We will request for 6 additional sessions so he can continue this.
- Ok to discontinue massage therapy, TENS dramatically increased his pain.
- If he does not respond to conservative measures, an evaluation at the Northern California functional restoration program would be indicated.
- Voltaren gel prescribed today.
- He is scheduled for QME on Jan 23, 2020.

Follow up in 4 weeks.

WORK STATUS:

WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
"I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.
*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

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040519008736

CC:
Kweller, Esq., Zachary : 12/02/2019
Castro, Mario : 12/02/2019
UR, Chubb : 12/02/2019

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 11/26/2019

8558 138 20201124 13 :01

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Apr 02, 2021
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

***

Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. He is not currently a surgical candidate for the neck.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expired in March 2021.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He is now attending chiropractic therapy and has completed 3/6 sessions so far with benefit. He notes a decrease in pain overall with these sessions and will continue to monitor his progress.

He is also approved for both neck and upper extremity PT, but he would prefer to finish chiropractic before initiating these.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

Patient reports seeing his QME about 2 weeks ago. We await this report.

Medical History:

***

PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.

4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1

2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1

3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

***

Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. Patient is currently attending chiropractic therapy instead with benefit and will monitor his progress. PT will be on hold for the time being.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These

are currently on hold due to COVID19 and they expired in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to dicuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical canddiate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. The patient understands this.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which he is pending with Dr. Solsar.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient saw Dr. Stoller again on 3/11/21. We await this report.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 15 minutes.

This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record ordering medications, tests or procedures To expedite

the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(c) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a

clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG

guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized

procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
4 Week(s)

CC:
Kweller, Esq., Zachary : 04/06/2021
Castro, Mario : 04/06/2021

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 04/05/2021

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Mar 04, 2021
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

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Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. We have this report for review.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expire in March 2021.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has never trialed chiropractic therapy before but is open to this today. He also would be interested in retrialing physical therapy for his symptos. Right after his injury he was doing PT but since his pain was so acute, it was difficult to tolerate. He has also trialed massage therapy in the past although this actually aggrevated his symptoms more.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

We have received his QME report from Dr. Stoller. This is reviewed below.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who imformed him this would improve with time. He does note overall improvement in his fatigue symptoms.

Medical History:

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PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.

2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of Physical Therapy Cervical Spine

x6 sessions of hand therapy for the bilateral elbows, wrists and hands.

Chiropractic Evaluation (99213) and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck Elbow Bilateral Elbows Wrist Bilateral Wrists Hand Bilateral Hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1
2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1
3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

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Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We will request for this report.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. At this time, we will request for a trial of chiropractic therapy instead. We will also sumbit for formal hand therapy as the patient's pain is not as acute as before and will likely tolerate this better.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19 and they expire in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to dicuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical canddiate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. THe patient understands this.

-Therefore, we will remain conservative with his care for the neck and will request for a trial of PT.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which he is pending with Dr. Solsar.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient will see Dr. Stoller again on 3/11/21.

Follow up in 4-6 weeks.

WORK STATUS:

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WORK STATUS: The patient is not permanent and stationary.

Work restrictions:

- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.

- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record reviewing consultation or non-office based diagnostic test results, To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

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(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Chiropractic Care - Cervical Spine Part 1: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic Care for the neck

Manipulation and Mobilization
Manipulation and mobilization are two types of manual therapy. These include wide arrays of different techniques and schools of thought. Some consider these two interventions to be on a spectrum of velocity and applied force. In general, mobilization involves assisted, low-force, low-velocity movement within or at the limit of joint range of motion. Manipulation involves higher-force, higher-velocity, and low-amplitude action with a focus on moving a target joint.

From the standpoint of evidence-based practice guidelines development, there are numerous types of manipulation utilized in many different studies.(562, 675, 897, 948-953) These issues result in difficulties comparing methods, techniques, or results across the available literature. Differences between techniques appear to be largely unstated in the available systematic reviews, which have aggregated all studies together. Adjustment is generally a synonym for manipulation in the chiropractic profession. There are studies evaluating thoracic manipulation for cervical pain without cervical manipulation.(954)

Many practitioners begin with lower force manipulation or mobilization techniques, and reserve higher force manipulation techniques for those who do not respond to lower force techniques to limit adverse effects and complications. Manipulation is generally considered a safe procedure, but like all other treatments is not without risks. For example, reported fatal outcomes have occurred and are particularly attributed to cervical manipulation.(932) Reports of more severe but rare adverse effects include vertebrobasilar dissection, carotid artery injury, and disc herniation or spinal cord compression myelopathy, although these reports need to be considered in the context of natural progressions of cervical pain without any intervention.(955) The mean age of patients experiencing vertebrobasilar dissection in the case reports is 38 and the risk has been reportedly due to cervical manipulation with a rotary component.(932) However, more recent population based studies have questioned the incidence of vascular injury from manipulation, suggesting instead that this may more often be an acceleration or natural progression of an event in progress.(956) Mobilization is less likely to lead to side effects than is manipulation.

The most common adverse response to neck manipulation is local discomfort that resolves within 24 to 48 hours.(932) (Hurwitz AJPH 02)There have been reports of vertebral artery dissection that result in posterior circulation stroke purportedly following cervical manipulation.(948) There has been much debate on the frequency of these events and multiple reports suggest low risk.(957) Population-based case control study of all patients who seek chiropractic care in

Ontario revealed a frequency of 8 cases occurred within 7 days of receiving chiropractic care in 109 million person years of observation in Ontario.(956) Of particular interest was the observation that the odds ratio of a stroke occurring after a primary physician visit for cervical pain was the same as that noted following a chiropractic office visits, raising doubt as to whether there is any relationship between the manipulation and stroke. Vertebral artery dissections are heralded by cervical pain and frequently headache that can bring a patient to either a chiropractor or general physician's office, and if not recognized can progress to stroke that can be fatal. This should be considered in the differential diagnosis of cervical pain.

Manipulation/Mobilization for Acute, Subacute, or Chronic Cervicothoracic Pain

Recommended. Manipulation/mobilization of the cervical and/or thoracic spine is recommended for short-term relief of cervical pain or as a component of an active treatment program focusing on active exercises for acute cervicothoracic pain. However, high amplitude, high velocity manipulation is not recommended.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Benefits: Potential for faster resolution of pain and improved function.

Harms: Worsening of neck pain, especially immediately after manipulation.

Frequency/Dose/Duration: Dependent on severity. Most patients with more severe spine conditions may receive up to 12 visits over 6 to 8 weeks, typically one to 3 times a week;(958-960) total treatments dependent on response to therapy. Substantial progression (e.g., return to work or activities, increasing ability to tolerate exercise, reduced medication use) should be documented at each follow-up visit. Treatment plan should be reassessed after each 2-week interval. Most guidelines suggest that if there is significant response in the above outcomes, it is worth considering another 2 weeks of treatment. If no response to 2 weeks of application of a particular manipulation treatment, it should be discontinued and 2 weeks of a different method of manipulation/mobilization or other treatment should be considered. If there is no response after 4 weeks and two 2-week trials of different manipulation/mobilization techniques, it is unlikely that further manipulation/mobilization will be helpful.

Indications for Discontinuation: Lack of demonstrated continued functional response after 6 manipulation/mobilization sessions (2 trials of 2 or more different methods), resolution of symptoms, or failure to participate in an active rehabilitation program.

Rationale: Multiple studies evaluate thoracic and cervical spine manipulation, (537, 932) whereas other studies evaluated one or the other.(949, 959, 961-964) Other studies do not delineate between the two different types of therapies.(578, 579, 675, 679, 965, 966).

There are no quality trials comparing mobilization to sham or placebo for treatment of acute

cervical pain. The closest study appears to be that of Cleland et al (2007), but it was impaired by methodological limitations. Most studies compare mobilization to manipulation, or use mobilization as a component of other interventions, significantly weakening the ability to infer efficacy of manipulation.(581) Most studies had small samples sizes with most <70.(959, 960, 967, 968) A moderate-quality trial evaluating mobilization suggested greater benefit compared with directed exercise and continued care by a general practitioner. However, this study included acute, subacute, and chronic pain without delineation between duration in the results, and the general practitioner care appeared to fail to include treatments thought to be efficacious.(565) A moderate-quality trial comparing cervical manipulation to mobilization suggested improvement in pain and range of motion in both groups after a single treatment, but manipulation was reportedly associated with overall better pain improvement on the NRS-101 and larger gains in range of motion.(6) Thus, the available quality evidence conflicts on treatment of cervicothoracic pain.(969) Hoving suggested mobilization is a favorable treatment option for patients with cervical pain compared with directed exercise or continued care by a general practitioner, although the general medical care may have been suboptimal.(565)

There are no sham-controlled trials of manipulation. Only a few RCTs evaluated subacute cervicothoracic pain and did so in combination with chronic cervicothoracic pain without reporting findings based on duration of symptoms. (960) A moderate-quality study comparing a single episode of cervical manipulation versus mobilization in subacute and chronic patients reported manipulation to have greater improvement in cervicothoracic pain at rest and active range of motion.(961) A moderate-quality study that did not describe well the duration of symptoms found an increase in range of motion after a single thoracic spine manipulation compared to no intervention.(970) (Krauss 08) Where another study compared manipulation and exercises alone and in combination and reported no significant clinical differences at 12-month follow up in chronic pain patients.(537)

A moderate-quality study of patients with chronic pain examined manipulation, manipulation and exercise and an exercise only group. They found that the manipulation alone group had less improvement compared to manipulation with exercise and exercises alone at 16 months after 11 weeks of treatment.(537) One study of 119 patients with cervicothoracic pain greater than 3 months duration reported improvement in all groups, but did not find any difference in the manipulation group when compared to physiotherapy and intensive training of cervical musculature for 6 weeks.(548) A moderate-quality study suggested acupuncture was more effective than manipulation or medications in treating chronic cervical pain.(675) Another moderate-quality study compared manipulation with sham ultrasound to sham ultrasound alone and suggested an improvement in pain in the manipulation group at 12 weeks.(971) While the RCTs show that other interventions are equally beneficial, the manipulation groups also experienced significant improvement in pain control and range of motion. Manipulation in subacute and chronic cervicothoracic pain is recommended and is best utilized in combination with an active exercise program.(537, 972) It was not possible to determine which technique was beneficial for which patient populations. There was also insufficient evidence for cervicothoracic pain with radicular findings.

A study evaluated a Clinical Prediction Rule for cervicothoracic pain using thoracic manipulation

that is somewhat analogous to those for the lumbar spine (see Low Back Disorders guideline). They reported predictors for increasing the likelihood of a positive outcome with thoracic manipulation.(973, 974) These 6 variables were symptoms <30 days, no symptoms distal to the shoulder, neck extension does not aggravate pain, FABQPA score <12, diminished upper thoracic spine kyphosis, and cervical extension ROM <30 degrees. Once this information has been reproduced and validated there may be a group of patients identified where thoracic manipulation may be recommended with greater specificity. However, a recent RCT reported that the above CPR was not able to be validated.(975) Another group assessed a clinical prediction rule and noted better response to treatment if: initial Neck Disability Index <11.5, bilateral involvement pattern, no sedentary work >5 hours a day, feeling better while moving the neck, not worse while extending the neck, and a diagnosis of spondylosis without radiculopathy.(976)

Evidence: There are 4 high-quality RCTs (562, 679, 986, 987) and 76 moderate-quality RCTs or crossover trials (one with two reports) incorporated into this analysis.(6, 222, 497, 536, 537, 544, 548, 565, 567, 573, 574, 576, 578, 579, 581, 584, 675, 676, 897, 932, 949, 950, 958, 959, 961-963, 965-971, 977-979, 981-985, 988-1021) There are 25 low-quality (617, 867, 1022-1046) RCTs and 5 other studies (964, 1044, 1046-1048) in Appendix 1.

A comprehensive literature search was conducted using multiple search engines including PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: manipulation and mobilization, disorder terms-cervicalgia, neck pain, cervical pain, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular pain, intervertebral disc displacement, herniated, herniat*, displacement, displacements, displaced, disk, disc, disks, discs, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Non-experimental Studies. In PubMed we found and reviewed 756 articles, and considered 130 for inclusion. In Scopus, we found and reviewed 1,436 articles, and considered 5 for inclusion. In CINAHL, we found and reviewed 134 articles, and considered 8 for inclusion. In Cochrane Library, we found and reviewed 32 articles, and considered 0 for inclusion. We also considered for inclusion 0 articles from other sources. Of the 143 articles considered for inclusion, 104 randomized trials and 13 systematic studies met the inclusion criteria.

Physical Therapy - Cervical spine: The following has been recommended by the MTUS/ACOEM regarding physical therapy for the cervical spine.

Physical Therapy, Occupational Therapy or Other Professionals for Mild to Moderate Acute, Subacute, or Chronic Cervical and Thoracic Pain

Recommended. One or two visits to physical therapy, occupational therapy, or other professionals to initiate and reinforce an exercise program are recommended for mild to moderate acute, subacute, or chronic cervical and thoracic pain.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence Low

Indications: Mild to moderate spine pain that is felt to be mostly manageable by self-care.

Benefits: Increased probability of engaging in an exercise program. Potential reinforcement with provider recommendations.

Harms: Medicalization, prolongation and increased risk of chronicity.

Frequency/Dose/Duration: One or two visits to initiate and then reinforce an exercise program especially for acute pain. A third appointment may be needed later for a final visit. More appointments may be indicated for establishment and engagement in an active exercise program (see Exercise Section). For subacute or chronic spine pain and/or more severely and/or debilitated patients may need 4 to 6 appointments to initiate and begin to reinforce an exercise program.

Evidence: There are 13 moderate-quality RCTs incorporated into this analysis.(489, 499, 501, 565, 595, 854-861) There are 9 low-quality RCTs in Appendix 1.(495, 548, 579, 862-867)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: physical therapy, occupational therapy, physiotherapy, cervicalgia, neck pain, cervical pain, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular pain, intervertebral disc displacement, herniated, herniat*, displacement, displacements, displaced, disk, disc, disks, discs, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. In PubMed, we found and reviewed 1,030 articles, and considered 25 for inclusion. In Scopus, we found and reviewed 2,759 articles, and considered two for inclusion. In CINAHL, we found and reviewed 94 articles, and considered zero for inclusion. In Cochrane Library, we found and reviewed 21 articles, and considered zero for inclusion. We also considered for inclusion two articles from other sources. Of the 29 articles considered for inclusion, 22 randomized trials and 7 systematic studies met the inclusion criteria.

Chiropractic care - Elbow: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic care for the elbow

Manipulation and Mobilization for Acute, Subacute, or Chronic Epicondylalgia

Not Recommended. Manipulation or mobilization is not recommended for the treatment of acute, subacute, or chronic lateral epicondylalgia.
Strength of Evidence – Not Recommended, Evidence (C)

Rationale: One high-quality trial included manipulation in addition to exercises and found no long-term benefits. (230)(Coombes 13) There is 1 moderate-quality randomized controlled trial comparing the additive value of soft tissue mobilization to a combination of stretching exercises, computer workstation advice plus generic NSAID. (261) (Blanchette 11) As that trial also found no evidence of additive benefits of soft tissue mobilization, neither manipulation nor mobilization is recommended for treatment of lateral epicondylalgia.

While there are a few moderate-quality trials, there are no sham-controlled trials that address manipulation or for the treatment of lateral epicondylalgia. One moderate-quality trial utilized manipulation as a co-intervention, thus precluding use of the trial for evidence based guidance.(13, 232) Two other moderate-quality studies conflicted. One suggested manipulation (mostly of the wrist) was superior to a combination of friction massage, ultrasound and exercise.(251) The other suggested ultrasound was superior to chiropractic care.(235) Thus, the currently available evidence conflicts regarding whether manipulation is beneficial and there is no recommendation for or against use of manipulation.
Evidence: There is 1 high- and 5 moderate-quality RCTs or randomized crossover experimental studies (one with two reports) incorporated in this analysis. There are 5 low-quality RCTs(190, 255, 256, 258, 260) (Radpasand 09) in Appendix 1.

Physical Therapy - Elbow: The following has been recommended by the MTUS/ACOEM Guidelines regarding Physical therapy for the elbow

Physical or Occupational Therapy for Acute, Subacute, Chronic, or Post-operative Lateral Epicondylalgia

Recommended. Physical or occupational therapy is recommended for the treatment of acute, subacute, chronic, or post-operative lateral epicondylalgia.
Strength of Evidence – Recommended, Insufficient Evidence (I)

Indications: For highly select acute, subacute, chronic and post-operative epicondylalgia patients. Generally moderately to severely affected patients are thought to be better candidates for supervised therapy sessions. Milder cases may benefit from no more than 2 or 3 appointments to help educate, prevent debility, and institute a home exercise program. One moderate-quality trial suggested no benefits from earlier physical therapy.(231) (Park 10)

Frequency/Dose/Duration: Exercises are generally individualized and increased over time. Many therapists combine exercises with other treatment modalities. Stretching exercises are frequently included and progress to strengthening exercises. However, there is no quality evidence to recommend one exercise regimen in preference to another. There also is no quality evidence in favor or against any single type of exercise (e.g., stretching or strengthening). Frequency of appointments is usually individualized based on severity of the disorder, prior response to treatment, and job demands. Two to three appointments per week for two weeks are often used to initiate an exercise program for more severely affected patients. Total numbers of appointments may be as few as 2 to 3 for mild patients or up to 12 to 15 for more severely affected patients.

Indications for Discontinuation: Resolution of elbow pain, intolerance, lack of efficacy or non-compliance including non-compliance with home exercises prescribed.

Rationale: There are multiple randomized studies of exercise; however, there is no trial with a sham group. There also is no quality trial with only exercise as an isolated intervention. One high-quality trial suggested no long-term benefits of exercise for treatment of chronic lateral epicondylalgia patients, resulting in downgrading of this recommendation and inclusion of more selective criteria.(230) (Coombes 13) One moderate-quality trial suggested no benefits from immediate compared with delayed physical therapy.(231) (Park 10) There is one trial comparing physiotherapy with wait and see and injection; however, the physiotherapy included multiple cointerventions that also included manipulation.(13, 232) This trial also found equivalency between the physiotherapy and wait-and-see groups at one year, although injection was superior in the short-term. The other moderate-quality trial with a noninterventional control group appears underpowered, as there were small sample sizes and trends in the data in support of exercise.(233) That trial also found no additive benefit of exercise in addition to glucocorticoid injection, although trends in support of a combined approach were also present in the data. One moderate-quality trial found an exercise group superior to ultrasound, potentially suggesting modest benefits from exercise(226) and the follow-up study also reported superior results with less need of surgery in the exercise group compared to ultrasound (6% vs. 36%).(234) Most trials have unstructured physical therapy that precludes identification of the effects of a specific exercise program, although one trial failed to discern differences between eccentric and concentric exercises.(227) Thus, there is no quality evidence of efficacy of exercise. Nevertheless, the large numbers of trials with exercise included as a co-intervention(12, 13, 195, 203, 204, 222-228, 235) documents that exercise is thought to be important for treatment and recovery. Exercise is not invasive, has low adverse effects, is low to high cost depending on numbers of treatments and is recommended.

Evidence: There are 2 high- and 9 moderate-quality RCTs (one with 2 reports) incorporated into this analysis. There are 6 low-quality RCTs or pseudorandomized controlled trials(193, 204, 206, 220, 236, 237) (Dwars 90; Svernlov 01; Luginbuhl 08; Clements 93; Croisier 07; Tyler 10) in Appendix 1.

Chiropractic Care - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic care

Manipulation and Mobilization
Manipulation and mobilization are two types of manual therapy which have been used for treatment of CTS.(613, 627, 813-818) These include wide arrays of different techniques and schools of thought. Some consider these two interventions to be on a spectrum of velocity and applied force. In general, mobilization involves assisted, low-force, low-velocity movement. Manipulation involves high-force, high-velocity, and low-amplitude action with a focus on moving a target joint (see Chronic Pain and Low Back Disorders Guidelines for more details).

Manipulation of the Wrist Acute, Subacute, or Chronic CTS
No Recommendation. There is no recommendation for or against the use of manipulation of the

wrist for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – No Recommendation, Insuffcient Evidence (I)
Level of Confidence Low

Manipulation of the Spine for Acute, Subacute, or Chronic CTS
Not Recommended. Manipulation of the spine is not recommended for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – Not Recommended, Insuffcient Evidence (I)
Level of Confidence – High

Rationale: There are two moderate-quality studies that evaluate manipulation for treatment of CTS. However, both have considerable methodological problems. One study compared manipulation plus ultrasound versus ibuprofen. Exclusion criteria did not exclude prior ibuprofen use, which is may well have been widespread, resulting in a comparison analogous to no treatment, which biases towards the other treatment arm, ibuprofen use was PRN after 2 weeks, subject contact time differed between groups, all biasing in favor of manipulation plus ultrasound. That study failed to find improvements compared with ibuprofen(637) which as noted previously appear ineffective. The other moderate-quality study had two active-treatment arms.(819) Thus, there is no quality study showing manipulation is effective as a treatment for CTS. Manipulation is not invasive, is moderately costly, but does have rare adverse effects from cervical manipulation. Cervical manipulation is not recommended for treatment of CTS. There is no recommendation for or against manipulation of the wrist as there is an absence of quality evidence.

Evidence: There are 2 moderate-quality RCTs incorporated into this analysis.(637, 819) There are 3 low-quality RCTs in Appendix 2.(625, 820, 821)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: manipulation or mobilization / carpal tunnel, median nerve, median, carpal, disease, entrapment, neuropathy, syndrome, compression, CTS, burning, itching, numbness, tingling, hand, palm, finger, wrist, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 38 articles in PubMed, 172 in Scopus, 26 in CINAHL, and 10 in Cochrane Library. We considered for inclusion 3 from PubMed, 8 from Scopus, 3 from CINAHL, 1 from Cochrane Library and 0 from other sources. Of the 15 articles considered for inclusion, 3 randomized trials and 8 systematic studies met the inclusion criteria.

Physical Therapy - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Physical therapy

Physical or Occupational Therapy for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain
No Recommendation. There is no recommendation for or against the use of physical or occupational therapy for treatment of acute, subacute, or chronic non-specific hand, wrist, or

forearm pain.
Strength of Evidence – No Recommendation, Insufficient Evidence (I)
Level of Confidence Low

Rationale: There are no quality studies evaluating any of the physical or occupational therapy modalities for treatment of non-specific hand, wrist, or forearm pain. (A case series of hand rehabilitation with occupational therapy services suggested benefits of occupational therapy for patients with heterogenous disorders.) Thus, treatments administered are empiric. These treatments are not invasive, have few adverse effects, but are moderate to high cost depending on number of treatments. They are generally not indicated for initial treatment. They may be more reasonable for more persistent cases. Trials of these modalities may be helpful in cases that do not resolve with initial treatment methods outlined above. However, these treatments are empiric and thus the success may be limited. Thus, there is no recommendation for or against these modalities.
Evidence: There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms physical therapy, occupational therapy, nonspecific, non-specific, hand pain, wrist pain, forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 13 articles in PubMed, 172 in Scopus, 8 in CINAHL, 3 in Cochrane Library, 150 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Exercise
Exercise is not generally indicated acutely. One moderate quality study of mostly chronic patients found no differences between two types of exercise programs, but had no control group.(1130) Many patients with chronic findings, functional deficits and post-operative patients require some appointments to at minimum help institute a home exercise program. For those with residual deficits, particularly post-operatively, see section on Post-Operative Rehabilitation and Rehabilitation of Patients with Functional Deficits: CTS and Other Disorders.

Evidence: There is 1 moderate-qualtiy RCT incorporated into this analysis.(1161)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library and Google Scholar without date limits using the following terms exercise, physical activity, non-specific Hand, Wrist, Forearm Pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 14 articles in PubMed, 38 in Scopus, 1 in CINAHL, 3 in Cochrane Library, and 437 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 in Google Scholar and 0 from other sources. Of the 1 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical

lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance

needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
4 Week(s)

CC:
Kweller, Esq., Zachary : 03/08/2021
Castro, Mario : 03/08/2021
Kweller, Esq., Zachary : 03/09/2021

Castro, Mario : 03/09/2021
UR, Chubb : 03/09/2021

This visit note has been electronically signed off by Fellows, Julia, PA-C on 03/04/2021

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley 09/27/1978 Date 03/04/2021

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ 6 sessions of Physical Therapy Cervical Spine

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

☐ Mark Phillips, P.A.
DEA#: MP0998558 / LIC#: PA17702

☑ Babak Jamasbi, M.D.
DEA#: BJ2563345 / LIC#: G70042

☐ Timothy Lo, M.D.
DEA#: FL0167901 / LIC#: A92580

☐ Brendan Morley, M.D.
DEA#: BM3191133 / LIC#: G74102

☐ Arzhang Zereshki, M.D.
DEA#: FZ3404477 / LIC#: A119704

☐ Neil K. Kamdar, M.D.
DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Filip Cheng, D.O.
DEA#: FC9695353 / LIC#: 20A18435

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Cynthia Uba, P.A.
DEA#: MU5564655 / LIC#: PA57425

☐ Giulia Ferrara, P.A.
DEA#: MF5991597 / LIC#: PA58278

POS Reorder # 1916761

040519008736

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley Date 03/04/2021

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ x6 sessions of hand therapy for the bilateral elbows, wrists and hands

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm

Refill	

☐ Do Not Substitute

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DEA#: MU5564655 / LIC#: PA57425

☐ Giulia Ferrara, P.A.
DEA#: MF5991597 / LIC#: PA58278

POS Reorder # 1916761

040519008736

Pain and Rehabilitative Consultants Medical Group

1335 Stanford Avenue
Emeryville, CA 94608
Telephone (510) 647-5101 • Fax (510) 647-5105

Name Jonathan Shockley Date 03/04/2021

Address 1000 Sutter St Room 123 San Francisco, CA 94109

℞ Chiropractic Evaluation (99213) and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck Elbow Bilateral Elbows Wrist Bilateral Wrists Hand Bilateral Hands

M70.832 Other soft tissue disorders related to use, overuse and pressure, left forearm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
G56.20 Lesion of ulnar nerve, unspecified upper limb

Refill	

☐ Do Not Substitute

M.D.

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DEA#: FZ3404477 / LIC#: A119704

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DEA#: FK5223172 / LIC#: A144608

☐ John W. Alchemy, M.D.
DEA#: BP4661369 / LIC#: 55085

☐ Filip Cheng, D.O.
DEA#: FC9695353 / LIC#: 20A18435

☐ Susie Paik, P.A.-C
DEA#: MP1537856 / LIC#: PA19005

☐ Donny J. Cho, P.A.-C
DEA#: MC2432386 / LIC#: PA21642

☐ Julia M. Fellows, P.A.-C
DEA#: MF4602288 / LIC#: 55158

☐ Cynthia Uba, P.A.
DEA#: MU5564655 / LIC#: PA57425

☐ Giulia Ferrara, P.A.
DEA#: MF5991597 / LIC#: PA58278

POS Reorder # 1916761

040519008736

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD | Filip Cheng, DO

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Julia Fellows, PA-C

Encounter Date: Mar 04, 2021
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

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Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. He was approved to a consult and met with Dr. Slosar on 2/4/21. We have this report for review.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expire in March 2021.

Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied by IMR. He has never trialed chiropractic therapy before but is open to this today. He also would be interested in retrialing physical therapy for his symptos. Right after his injury he was doing PT but since his pain was so acute, it was difficult to tolerate. He has also trialed massage therapy in the past although this actually aggrevated his symptoms more.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

We have received his QME report from Dr. Stoller. This is reviewed below.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who imformed him this would improve with time. He does note overall improvement in his fatigue symptoms.

Medical History:

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PAST MEDICAL HISTORY

1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY

1. Adenoidectomy in 1987.

2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of Physical Therapy Cervical Spine

x6 sessions of hand therapy for the bilateral elbows, wrists and hands.

Chiropractic Evaluation (99213) and 6 sessions of Chiropractic Treatment 98941, 97140, G0283, 97012. Neck Elbow Bilateral Elbows Wrist Bilateral Wrists Hand Bilateral Hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:

Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1
2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1
3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:

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Assessment:

This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We will request for this report.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied by IMR. At this time, we will request for a trial of chiropractic therapy instead. We will also sumbit for formal hand therapy as the patient's pain is not as acute as before and will likely tolerate this better.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19 and they expire in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. He met with Dr. Solsar to dicuss his neck and upper extremity symptoms. Per this report, Dr. Slosar does not find him to be a surgical canddiate as cervical spine surgery will likely not lead to improvement of his upper extremity pain. THe patient understands this.

-Therefore, we will remain conservative with his care for the neck and will request for a trial of PT.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which he is pending with Dr. Solsar.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

-Patient will see Dr. Stoller again on 3/11/21.

Follow up in 4-6 weeks.

WORK STATUS:

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WORK STATUS: The patient is not permanent and stationary.

Work restrictions:

- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.

- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
For this visit the total time the provider spent for the encounter is the most appropriate determinate of the level of service. The time reported includes the direct face to face time with patient and the total time spent 20 minutes This includes: counseling and educating the patient, family or caregiver, documenting clinical information in the electronic health record reviewing consultation or non-office based diagnostic test results, To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Chiropractic Care - Cervical Spine Part 1: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic Care for the neck

Manipulation and Mobilization
Manipulation and mobilization are two types of manual therapy. These include wide arrays of different techniques and schools of thought. Some consider these two interventions to be on a spectrum of velocity and applied force. In general, mobilization involves assisted, low-force, low-velocity movement within or at the limit of joint range of motion. Manipulation involves higher-force, higher-velocity, and low-amplitude action with a focus on moving a target joint.

From the standpoint of evidence-based practice guidelines development, there are numerous types of manipulation utilized in many different studies.(562, 675, 897, 948-953) These issues result in difficulties comparing methods, techniques, or results across the available literature. Differences between techniques appear to be largely unstated in the available systematic reviews, which have aggregated all studies together. Adjustment is generally a synonym for manipulation in the chiropractic profession. There are studies evaluating thoracic manipulation for cervical pain without cervical manipulation.(954)

Many practitioners begin with lower force manipulation or mobilization techniques, and reserve higher force manipulation techniques for those who do not respond to lower force techniques to limit adverse effects and complications. Manipulation is generally considered a safe procedure, but like all other treatments is not without risks. For example, reported fatal outcomes have occurred and are particularly attributed to cervical manipulation.(932) Reports of more severe but rare adverse effects include vertebrobasilar dissection, carotid artery injury, and disc herniation or spinal cord compression myelopathy, although these reports need to be considered in the context of natural progressions of cervical pain without any intervention.(955) The mean age of patients experiencing vertebrobasilar dissection in the case reports is 38 and the risk has been reportedly due to cervical manipulation with a rotary component.(932) However, more recent population based studies have questioned the incidence of vascular injury from manipulation, suggesting instead that this may more often be an acceleration or natural progression of an event in progress.(956) Mobilization is less likely to lead to side effects than is manipulation.

The most common adverse response to neck manipulation is local discomfort that resolves within 24 to 48 hours.(932) (Hurwitz AJPH 02)There have been reports of vertebral artery dissection that result in posterior circulation stroke purportedly following cervical manipulation.(948) There has been much debate on the frequency of these events and multiple reports suggest low risk.(957) Population-based case control study of all patients who seek chiropractic care in

Ontario revealed a frequency of 8 cases occurred within 7 days of receiving chiropractic care in 109 million person years of observation in Ontario.(956) Of particular interest was the observation that the odds ratio of a stroke occurring after a primary physician visit for cervical pain was the same as that noted following a chiropractic office visits, raising doubt as to whether there is any relationship between the manipulation and stroke. Vertebral artery dissections are heralded by cervical pain and frequently headache that can bring a patient to either a chiropractor or general physician's office, and if not recognized can progress to stroke that can be fatal. This should be considered in the differential diagnosis of cervical pain.

Manipulation/Mobilization for Acute, Subacute, or Chronic Cervicothoracic Pain

Recommended. Manipulation/mobilization of the cervical and/or thoracic spine is recommended for short-term relief of cervical pain or as a component of an active treatment program focusing on active exercises for acute cervicothoracic pain. However, high amplitude, high velocity manipulation is not recommended.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Benefits: Potential for faster resolution of pain and improved function.

Harms: Worsening of neck pain, especially immediately after manipulation.

Frequency/Dose/Duration: Dependent on severity. Most patients with more severe spine conditions may receive up to 12 visits over 6 to 8 weeks, typically one to 3 times a week;(958-960) total treatments dependent on response to therapy. Substantial progression (e.g., return to work or activities, increasing ability to tolerate exercise, reduced medication use) should be documented at each follow-up visit. Treatment plan should be reassessed after each 2-week interval. Most guidelines suggest that if there is significant response in the above outcomes, it is worth considering another 2 weeks of treatment. If no response to 2 weeks of application of a particular manipulation treatment, it should be discontinued and 2 weeks of a different method of manipulation/mobilization or other treatment should be considered. If there is no response after 4 weeks and two 2-week trials of different manipulation/mobilization techniques, it is unlikely that further manipulation/mobilization will be helpful.

Indications for Discontinuation: Lack of demonstrated continued functional response after 6 manipulation/mobilization sessions (2 trials of 2 or more different methods), resolution of symptoms, or failure to participate in an active rehabilitation program.

Rationale: Multiple studies evaluate thoracic and cervical spine manipulation, (537, 932) whereas other studies evaluated one or the other.(949, 959, 961-964) Other studies do not delineate between the two different types of therapies.(578, 579, 675, 679, 965, 966).

There are no quality trials comparing mobilization to sham or placebo for treatment of acute

cervical pain. The closest study appears to be that of Cleland et al (2007), but it was impaired by methodological limitations. Most studies compare mobilization to manipulation, or use mobilization as a component of other interventions, significantly weakening the ability to infer efficacy of manipulation.(581) Most studies had small samples sizes with most <70.(959, 960, 967, 968) A moderate-quality trial evaluating mobilization suggested greater benefit compared with directed exercise and continued care by a general practitioner. However, this study included acute, subacute, and chronic pain without delineation between duration in the results, and the general practitioner care appeared to fail to include treatments thought to be efficacious.(565) A moderate-quality trial comparing cervical manipulation to mobilization suggested improvement in pain and range of motion in both groups after a single treatment, but manipulation was reportedly associated with overall better pain improvement on the NRS-101 and larger gains in range of motion.(6) Thus, the available quality evidence conflicts on treatment of cervicothoracic pain.(969) Hoving suggested mobilization is a favorable treatment option for patients with cervical pain compared with directed exercise or continued care by a general practitioner, although the general medical care may have been suboptimal.(565)

There are no sham-controlled trials of manipulation. Only a few RCTs evaluated subacute cervicothoracic pain and did so in combination with chronic cervicothoracic pain without reporting findings based on duration of symptoms. (960) A moderate-quality study comparing a single episode of cervical manipulation versus mobilization in subacute and chronic patients reported manipulation to have greater improvement in cervicothoracic pain at rest and active range of motion.(961) A moderate-quality study that did not describe well the duration of symptoms found an increase in range of motion after a single thoracic spine manipulation compared to no intervention.(970) (Krauss 08) Where another study compared manipulation and exercises alone and in combination and reported no significant clinical differences at 12-month follow up in chronic pain patients.(537)

A moderate-quality study of patients with chronic pain examined manipulation, manipulation and exercise and an exercise only group. They found that the manipulation alone group had less improvement compared to manipulation with exercise and exercises alone at 16 months after 11 weeks of treatment.(537) One study of 119 patients with cervicothoracic pain greater than 3 months duration reported improvement in all groups, but did not find any difference in the manipulation group when compared to physiotherapy and intensive training of cervical musculature for 6 weeks.(548) A moderate-quality study suggested acupuncture was more effective than manipulation or medications in treating chronic cervical pain.(675) Another moderate-quality study compared manipulation with sham ultrasound to sham ultrasound alone and suggested an improvement in pain in the manipulation group at 12 weeks.(971) While the RCTs show that other interventions are equally beneficial, the manipulation groups also experienced significant improvement in pain control and range of motion. Manipulation in subacute and chronic cervicothoracic pain is recommended and is best utilized in combination with an active exercise program.(537, 972) It was not possible to determine which technique was beneficial for which patient populations. There was also insufficient evidence for cervicothoracic pain with radicular findings.

A study evaluated a Clinical Prediction Rule for cervicothoracic pain using thoracic manipulation

that is somewhat analogous to those for the lumbar spine (see Low Back Disorders guideline). They reported predictors for increasing the likelihood of a positive outcome with thoracic manipulation.(973, 974) These 6 variables were symptoms <30 days, no symptoms distal to the shoulder, neck extension does not aggravate pain, FABQPA score <12, diminished upper thoracic spine kyphosis, and cervical extension ROM <30 degrees. Once this information has been reproduced and validated there may be a group of patients identified where thoracic manipulation may be recommended with greater specificity. However, a recent RCT reported that the above CPR was not able to be validated.(975) Another group assessed a clinical prediction rule and noted better response to treatment if: initial Neck Disability Index <11.5, bilateral involvement pattern, no sedentary work >5 hours a day, feeling better while moving the neck, not worse while extending the neck, and a diagnosis of spondylosis without radiculopathy.(976)

Evidence: There are 4 high-quality RCTs (562, 679, 986, 987) and 76 moderate-quality RCTs or crossover trials (one with two reports) incorporated into this analysis.(6, 222, 497, 536, 537, 544, 548, 565, 567, 573, 574, 576, 578, 579, 581, 584, 675, 676, 897, 932, 949, 950, 958, 959, 961-963, 965-971, 977-979, 981-985, 988-1021) There are 25 low-quality (617, 867, 1022-1046) RCTs and 5 other studies (964, 1044, 1046-1048) in Appendix 1.

A comprehensive literature search was conducted using multiple search engines including PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: manipulation and mobilization, disorder terms-cervicalgia, neck pain, cervical pain, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular pain, intervertebral disc displacement, herniated, herniat*, displacement, displacements, displaced, disk, disc, disks, discs, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Non-experimental Studies. In PubMed we found and reviewed 756 articles, and considered 130 for inclusion. In Scopus, we found and reviewed 1,436 articles, and considered 5 for inclusion. In CINAHL, we found and reviewed 134 articles, and considered 8 for inclusion. In Cochrane Library, we found and reviewed 32 articles, and considered 0 for inclusion. We also considered for inclusion 0 articles from other sources. Of the 143 articles considered for inclusion, 104 randomized trials and 13 systematic studies met the inclusion criteria.

Physical Therapy - Cervical spine: The following has been recommended by the MTUS/ACOEM regarding physical therapy for the cervical spine.

Physical Therapy, Occupational Therapy or Other Professionals for Mild to Moderate Acute, Subacute, or Chronic Cervical and Thoracic Pain

Recommended. One or two visits to physical therapy, occupational therapy, or other professionals to initiate and reinforce an exercise program are recommended for mild to moderate acute, subacute, or chronic cervical and thoracic pain.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence Low

Indications: Mild to moderate spine pain that is felt to be mostly manageable by self-care.

Benefits: Increased probability of engaging in an exercise program. Potential reinforcement with provider recommendations.

Harms: Medicalization, prolongation and increased risk of chronicity.

Frequency/Dose/Duration: One or two visits to initiate and then reinforce an exercise program especially for acute pain. A third appointment may be needed later for a final visit. More appointments may be indicated for establishment and engagement in an active exercise program (see Exercise Section). For subacute or chronic spine pain and/or more severely and/or debilitated patients may need 4 to 6 appointments to initiate and begin to reinforce an exercise program.

Evidence: There are 13 moderate-quality RCTs incorporated into this analysis.(489, 499, 501, 565, 595, 854-861) There are 9 low-quality RCTs in Appendix 1.(495, 548, 579, 862-867)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: physical therapy, occupational therapy, physiotherapy, cervicalgia, neck pain, cervical pain, neck, cervical, vertebrae, vertebral, spine, radiculopathy, radiculopathies, radicular pain, intervertebral disc displacement, herniated, herniat*, displacement, displacements, displaced, disk, disc, disks, discs, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. In PubMed, we found and reviewed 1,030 articles, and considered 25 for inclusion. In Scopus, we found and reviewed 2,759 articles, and considered two for inclusion. In CINAHL, we found and reviewed 94 articles, and considered zero for inclusion. In Cochrane Library, we found and reviewed 21 articles, and considered zero for inclusion. We also considered for inclusion two articles from other sources. Of the 29 articles considered for inclusion, 22 randomized trials and 7 systematic studies met the inclusion criteria.

Chiropractic care - Elbow: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic care for the elbow

Manipulation and Mobilization for Acute, Subacute, or Chronic Epicondylalgia

Not Recommended. Manipulation or mobilization is not recommended for the treatment of acute, subacute, or chronic lateral epicondylalgia.
Strength of Evidence – Not Recommended, Evidence (C)

Rationale: One high-quality trial included manipulation in addition to exercises and found no long-term benefits. (230)(Coombes 13) There is 1 moderate-quality randomized controlled trial comparing the additive value of soft tissue mobilization to a combination of stretching exercises, computer workstation advice plus generic NSAID. (261) (Blanchette 11) As that trial also found no evidence of additive benefits of soft tissue mobilization, neither manipulation nor mobilization is recommended for treatment of lateral epicondylalgia.

While there are a few moderate-quality trials, there are no sham-controlled trials that address manipulation or for the treatment of lateral epicondylalgia. One moderate-quality trial utilized manipulation as a co-intervention, thus precluding use of the trial for evidence based guidance.(13, 232) Two other moderate-quality studies conflicted. One suggested manipulation (mostly of the wrist) was superior to a combination of friction massage, ultrasound and exercise.(251) The other suggested ultrasound was superior to chiropractic care.(235) Thus, the currently available evidence conflicts regarding whether manipulation is beneficial and there is no recommendation for or against use of manipulation.
Evidence: There is 1 high- and 5 moderate-quality RCTs or randomized crossover experimental studies (one with two reports) incorporated in this analysis. There are 5 low-quality RCTs(190, 255, 256, 258, 260) (Radpasand 09) in Appendix 1.

Physical Therapy - Elbow: The following has been recommended by the MTUS/ACOEM Guidelines regarding Physical therapy for the elbow

Physical or Occupational Therapy for Acute, Subacute, Chronic, or Post-operative Lateral Epicondylalgia

Recommended. Physical or occupational therapy is recommended for the treatment of acute, subacute, chronic, or post-operative lateral epicondylalgia.
Strength of Evidence – Recommended, Insufficient Evidence (I)

Indications: For highly select acute, subacute, chronic and post-operative epicondylalgia patients. Generally moderately to severely affected patients are thought to be better candidates for supervised therapy sessions. Milder cases may benefit from no more than 2 or 3 appointments to help educate, prevent debility, and institute a home exercise program. One moderate-quality trial suggested no benefits from earlier physical therapy.(231) (Park 10)

Frequency/Dose/Duration: Exercises are generally individualized and increased over time. Many therapists combine exercises with other treatment modalities. Stretching exercises are frequently included and progress to strengthening exercises. However, there is no quality evidence to recommend one exercise regimen in preference to another. There also is no quality evidence in favor or against any single type of exercise (e.g., stretching or strengthening). Frequency of appointments is usually individualized based on severity of the disorder, prior response to treatment, and job demands. Two to three appointments per week for two weeks are often used to initiate an exercise program for more severely affected patients. Total numbers of appointments may be as few as 2 to 3 for mild patients or up to 12 to 15 for more severely affected patients.

Indications for Discontinuation: Resolution of elbow pain, intolerance, lack of efficacy or non-compliance including non-compliance with home exercises prescribed.

Rationale: There are multiple randomized studies of exercise; however, there is no trial with a sham group. There also is no quality trial with only exercise as an isolated intervention. One high-quality trial suggested no long-term benefits of exercise for treatment of chronic lateral epicondylalgia patients, resulting in downgrading of this recommendation and inclusion of more selective criteria.(230) (Coombes 13) One moderate-quality trial suggested no benefits from immediate compared with delayed physical therapy.(231) (Park 10) There is one trial comparing physiotherapy with wait and see and injection; however, the physiotherapy included multiple cointerventions that also included manipulation.(13, 232) This trial also found equivalency between the physiotherapy and wait-and-see groups at one year, although injection was superior in the short-term. The other moderate-quality trial with a noninterventional control group appears underpowered, as there were small sample sizes and trends in the data in support of exercise.(233) That trial also found no additive benefit of exercise in addition to glucocorticoid injection, although trends in support of a combined approach were also present in the data. One moderate-quality trial found an exercise group superior to ultrasound, potentially suggesting modest benefits from exercise(226) and the follow-up study also reported superior results with less need of surgery in the exercise group compared to ultrasound (6% vs. 36%).(234) Most trials have unstructured physical therapy that precludes identification of the effects of a specific exercise program, although one trial failed to discern differences between eccentric and concentric exercises.(227) Thus, there is no quality evidence of efficacy of exercise. Nevertheless, the large numbers of trials with exercise included as a co-intervention(12, 13, 195, 203, 204, 222-228, 235) documents that exercise is thought to be important for treatment and recovery. Exercise is not invasive, has low adverse effects, is low to high cost depending on numbers of treatments and is recommended.

Evidence: There are 2 high- and 9 moderate-quality RCTs (one with 2 reports) incorporated into this analysis. There are 6 low-quality RCTs or pseudorandomized controlled trials(193, 204, 206, 220, 236, 237) (Dwars 90; Svernlov 01; Luginbuhl 08; Clements 93; Croisier 07; Tyler 10) in Appendix 1.

Chiropractic Care - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Chiropractic care

Manipulation and Mobilization
Manipulation and mobilization are two types of manual therapy which have been used for treatment of CTS.(613, 627, 813-818) These include wide arrays of different techniques and schools of thought. Some consider these two interventions to be on a spectrum of velocity and applied force. In general, mobilization involves assisted, low-force, low-velocity movement. Manipulation involves high-force, high-velocity, and low-amplitude action with a focus on moving a target joint (see Chronic Pain and Low Back Disorders Guidelines for more details).

Manipulation of the Wrist Acute, Subacute, or Chronic CTS
No Recommendation. There is no recommendation for or against the use of manipulation of the

wrist for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – No Recommendation, Insuffcient Evidence (I)
Level of Confidence Low

Manipulation of the Spine for Acute, Subacute, or Chronic CTS
Not Recommended. Manipulation of the spine is not recommended for treatment of acute, subacute, or chronic CTS.
Strength of Evidence – Not Recommended, Insuffcient Evidence (I)
Level of Confidence – High

Rationale: There are two moderate-quality studies that evaluate manipulation for treatment of CTS. However, both have considerable methodological problems. One study compared manipulation plus ultrasound versus ibuprofen. Exclusion criteria did not exclude prior ibuprofen use, which is may well have been widespread, resulting in a comparison analogous to no treatment, which biases towards the other treatment arm, ibuprofen use was PRN after 2 weeks, subject contact time differed between groups, all biasing in favor of manipulation plus ultrasound. That study failed to find improvements compared with ibuprofen(637) which as noted previously appear ineffective. The other moderate-quality study had two active-treatment arms.(819) Thus, there is no quality study showing manipulation is effective as a treatment for CTS. Manipulation is not invasive, is moderately costly, but does have rare adverse effects from cervical manipulation. Cervical manipulation is not recommended for treatment of CTS. There is no recommendation for or against manipulation of the wrist as there is an absence of quality evidence.

Evidence: There are 2 moderate-quality RCTs incorporated into this analysis.(637, 819) There are 3 low-quality RCTs in Appendix 2.(625, 820, 821)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: manipulation or mobilization / carpal tunnel, median nerve, median, carpal, disease, entrapment, neuropathy, syndrome, compression, CTS, burning, itching, numbness, tingling, hand, palm, finger, wrist, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 38 articles in PubMed, 172 in Scopus, 26 in CINAHL, and 10 in Cochrane Library. We considered for inclusion 3 from PubMed, 8 from Scopus, 3 from CINAHL, 1 from Cochrane Library and 0 from other sources. Of the 15 articles considered for inclusion, 3 randomized trials and 8 systematic studies met the inclusion criteria.

Physical Therapy - Hand, Wrist, Forearm: The following has been recommended by the MTUS/ACOEM Guidelines regarding Physical therapy

Physical or Occupational Therapy for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain
No Recommendation. There is no recommendation for or against the use of physical or occupational therapy for treatment of acute, subacute, or chronic non-specific hand, wrist, or

forearm pain.
Strength of Evidence – No Recommendation, Insufficient Evidence (I)
Level of Confidence Low

Rationale: There are no quality studies evaluating any of the physical or occupational therapy modalities for treatment of non-specific hand, wrist, or forearm pain. (A case series of hand rehabilitation with occupational therapy services suggested benefits of occupational therapy for patients with heterogenous disorders.) Thus, treatments administered are empiric. These treatments are not invasive, have few adverse effects, but are moderate to high cost depending on number of treatments. They are generally not indicated for initial treatment. They may be more reasonable for more persistent cases. Trials of these modalities may be helpful in cases that do not resolve with initial treatment methods outlined above. However, these treatments are empiric and thus the success may be limited. Thus, there is no recommendation for or against these modalities.
Evidence: There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms physical therapy, occupational therapy, nonspecific, non-specific, hand pain, wrist pain, forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 13 articles in PubMed, 172 in Scopus, 8 in CINAHL, 3 in Cochrane Library, 150 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Exercise
Exercise is not generally indicated acutely. One moderate quality study of mostly chronic patients found no differences between two types of exercise programs, but had no control group.(1130) Many patients with chronic findings, functional deficits and post-operative patients require some appointments to at minimum help institute a home exercise program. For those with residual deficits, particularly post-operatively, see section on Post-Operative Rehabilitation and Rehabilitation of Patients with Functional Deficits: CTS and Other Disorders.

Evidence: There is 1 moderate-qualtiy RCT incorporated into this analysis.(1161)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library and Google Scholar without date limits using the following terms exercise, physical activity, non-specific Hand, Wrist, Forearm Pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 14 articles in PubMed, 38 in Scopus, 1 in CINAHL, 3 in Cochrane Library, and 437 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 in Google Scholar and 0 from other sources. Of the 1 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical

lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance

needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
4 Week(s)

CC:
Kweller, Esq., Zachary : 03/08/2021
Castro, Mario : 03/08/2021

This visit note has been electronically signed off by Fellows, Julia, PA-C on 03/04/2021

SPINECARE
MEDICAL GROUP

455 Hickey Boulevard, Suite 310
Daly City, CA 94015
Phone: 650-985-7500

Patient Name: JONATHAN SHOCKLEY
Patient #: W202177
Date of Service: 02/04/2021

CONSULTATION

This is a new patient consultation.

HISTORY OF PRESENT ILLNESS: At the request of Dr. Babak and the pain management physicians caring for this patient, I was asked to perform a surgical consultation regarding the patient's cervical spine.

Of note, the patient on intake, reported that he was unable to fill out our questionnaire as he has problems with his hands which prevent him from writing. Therefore, at the time of this dictation, I have limited information which was obtained primarily by a verbal history. The patient reports that he will try to do this online when he gets back home and I will review it upon completion.

The patient reports that he was an EKG technician who had to do approximately 100 EKGs per hour while working. He states he has developed a repetitive stress injury and describes severe bilateral pain in his hands. The patient also reports neck pain. He reports right greater than left arm pain. He states some of his symptoms radiate from his neck into his right arm. He has lesser symptoms in the left arm. The patient also cannot easily describe a discrete pattern of pain as he states the symptoms tend to radiate throughout the entire arm and he describes pain, numbness, tingling, and difficulty with both hands nearly in their entirety rather than in discrete specific dermatomal regions.

The patient has had multiple nonoperative treatments including physical therapy, acupuncture, medication management. At this time, however, he has not had any spinal injections.

He has had EMG testing which has been positive for cubital tunnel syndrome. The EMG testing was negative for cervical radiculopathy or carpal tunnel syndrome.

CURRENT MEDICATIONS:

MEDICATION ALLERGIES: No known drug allergies.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: Negative.

FAMILY HISTORY: Negative.

REVIEW OF SYSTEMS:

SKIN/BREASTS: Negative for rashes, psoriasis, bruising, abnormal lumps, painful breasts.

EYES: Negative for visual loss, and double vision.

EARS: Negative for decreased hearing, ringing in the ears.

NOSE: Negative for sinus problems, breathing problems.

THROAT: Negative for sore throat, hoarseness, snoring.

CARDIOVASCULAR: Negative for palpitations, irregular heartbeat, heart murmur, rheumatic fever, chest pain.

RESPIRATORY: Negative for shortness of breath, wheezing, cough/sputum production.

GASTROINTESTINAL: Negative for weight loss, abdominal pain, nausea/vomiting, diarrhea or constipation, blood in stool.

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loss of bowel control.

MUSCULOSKELETAL: Negative for fractures/sprains, osteoporosis, joint swelling.

GENITOURINARY: Negative for blood in urine, increased frequency of urination, painful urination, loss of bladder control, kidney stones.

ENDOCRINE: Negative for enlarged thyroid/goiter, excessive thirst/appetite, diabetes.

NEUROLOGIC: Negative for headaches/migraine, vertigo/dizziness, convulsions/seizures, loss of consciousness.

All additional systems are negative.

PHYSICAL EXAMINATION: Cervical range of motion is approximately 70% of normal. Spurling's maneuvers are negative bilaterally.

Static strength neurologically demonstrates 5/5 strength in both upper extremities throughout with mildly bilateral decreased grip strength bilateral.

Sensory examination is intact in the extremities, but the patient describes diffuse numbness in the hands globally.

Reflexes are symmetric at 1+ biceps, 2+ triceps bilaterally.

Phalen's maneuver is slightly positive on the right at 45 seconds, slightly positive on the left at 60 seconds.

Tinel's signs at the wrist bilaterally negative.

Tinel's signs at the cubital tunnels are slightly positive bilaterally.

Observed gait normal heel to toe. No evidence of ataxia or myelopathy.

REVIEW OF IMAGING STUDIES: Cervical spine imaging including MRI, CT scans are reviewed.

MRI scan shows diffuse multi-level cervical disc degeneration, moderate C3-4, moderate to severe C4-5. C4-5 shows right greater than left stenosis.

At C5-6, there is moderate to severe central stenosis and narrowing.

At C6-7, there is left-sided foraminal and entry zone stenosis moderate to severe.

CT scan shows significant stenosis left at C6-7. Spondylosis is noted at the adjacent segments, C5-6, C4-5, and mildly at C3-4.

IMPRESSION:

1. Bilateral hand pain, etiology unclear.
2. Cervical spinal stenosis, C4-5 right, C6-7 left.
3. Repetitive stress injury, bilateral upper extremities.
4. EMG positive cubital tunnel.
5. EMG negative cervical radiculopathy, negative carpal tunnel.

DISCUSSION/PLAN: Today, I performed a consultation on this pleasant gentleman by performing an intake history verbally and examining him as noted above. I reviewed the patient's entire imaging, portfolio as described above, with specific attention of the cervical spine. The new patient intake form is reviewed and scanned now into the chart.

The patient's symptoms are difficult for me for ascertain. I cannot adequately explain his bilateral hand symptoms from his cervical spine alone. There may be overlap with some type of median nerve and/or ulnar nerve compression. The EMG was negative for cervical radiculopathy, and the patient's static strength testing and sensory examination are grossly intact except for his hands which are mildly weak and diminished in sensation across multiple dermatomes.

The patient more likely than not has some contribution of cervical spondylosis, neck pain, degeneration, cervical stenosis. He is also showing signs of cubital tunnel irritation as well as bilateral hand numbness.

I do not have a predictable surgical treatment option to offer this pleasant gentleman from a cervical spine surgery perspective. The patient does not have classic findings of radiculopathy and has a stable neurologic examination on testing and EMG. Therefore, to embark on a surgical intervention in the neck, he would more likely not require an anterior cervical discectomy with decompression at C6-7, fusion C5-6, C6-7, C4-5 which in my opionion, the results may be very unpredicable. Given the extensive nature of that surgery and the complexity, it would be probably best to be done at the University setting, given the difficulty ascertaining the exact pain generators. Currently, I would advise at this time against consideration of spine surgery, but other spine surgeons may have different opinions.

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Paul J. Slosar, MD
PJS/IM

Electronically signed by PAUL J SLOSAR, M.D.

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Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

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1335 Standford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Giulia Ferrara, PA-C

Encounter Date: Jan 21, 2021
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 42 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:
***

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Patient is presents via Facetime to follow up on pain in his arm, bilateral hands and neck.

Patient denies acute changes to his pain complaints today. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

Patient also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and the patient wanted to discuss the results with a specialist. However at the time, his insurance carrier was denying liability for his neck.

He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID 19. These sessions expire in March 2021. Previously, the patient had been attending acupuncture therapy with benefit, but additional sessions have been denied and are currently being appealed. He has never trialed chiropractic therapy before, but he prefers to wait and see if acupuncture will be appeal approved prior to proceeding with chiro. He has also trialed massage therapy in the past although this actually aggrevated his symptoms more.

With regard to medication, he continues with Lidocaine crean, voltaren gel & Flector patches as topical medications. These decrease his pain from 5/10 to 2/10 and prevents flare ups. He denies side effects with his medications. He does request for refills today.

We have received his QME report from Dr. Stoller. This is reviewed below.

Patient reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who imformed him this would improve with time.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.

5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

Family History:
*** FAMILY HISTORY
Patient does not have a family history of drug addiction.
Patient has a family history of chronic pain.

OBJECTIVE FINDINGS:
2014 E/M:

Constitutional - General Appearance:
Patient is near ideal body weight and is well groomed..
Orientation:
Patient is alert and oriented x3..
Mood and Affect:
Patient does not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply 2-3 grams to affected area upt o 4 times daily update sig
3. Flector 1.3% Patch Apply 1 patch to affected area 12hours on/off
4. Advil (OTC)
5. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00. REF: 1
2 Voltaren 1% Gel SIG: Apply 2-3 grams to affected area upt o 4 times daily QTY: 100.00. REF: 1
3 Flector 1.3% Patch SIG: Apply 1 patch to affected area 12hours on/off QTY: 30.00. REF: 1

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:

- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per this report, Dr. Gordon does not recommend any surgery. He also was not able to confirm the presense of ulnar neuropathy through physical exam despite it being present on the patient's EMG. The patient reportedly underwent a repeat EMG with Dr. Liberty Jenkins and apparently this report also showed the presense of ulnar neuropathy. We will request for this report.

- Given that Dr. Gordon does not recommend a surgical intervention, we attempted to submit for acupuncture with a change in material facts. However, this request was denied and is currently being appealed. We may consider trialing chiropractic therapy at his next visit should acupuncture remain denied.

- He has been approved for 6 sessions of aqua therapy for his wrists, hands, and elbows. These are currently on hold due to COVID19 and they expire in March 2021.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections.

-We reviewed the QME supplemental from Dr. Stoller. Per this report, he agrees that the patient's neck should be treated on an industrial basis and recommended that he see a specialist. In light of this finding, resubmitted for the consult and this was approved. He is being referred to Dr. Slosar and has an appointment on Feb 4.

- With regard to his work restrictions, we have indicated that he can perform 1 hour of computer work in an 8 hour day, we are unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which he is pending with Dr. Solsar.

- With regard to medications, Voltaren gel, Lidocaine ointment and Flector patch refilled today. Gabapentin discontinued due to side effects. As mentioned above, the patient has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had a abnormal TSH shortly after discontinuing gabapentin and he believe that he medication is responsible for the abnormal level. Since the patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. To expedite the process in which we may provide the appropriate treatment for our patient, please consider the following from California Labor Code section 4610:

(e) No person other than a licensed physician who is competent to

evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

-The services we are requesting fall under the specialty of "Interventional Pain Management" which is an official medical specialty as designated by the The Department of Health and Human Services Center for Medicare and Medicaid Services and which is defined as the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatments. Interventional pain management services are characterized often by the placement of surgical length needles in the spine or areas adjacent to the spine to deliver anesthetic agents, to remove scar tissue, or to deliver a solution designed to interrupt a nerve's ability to transmit a pain sensation.

Physicians from many backgrounds including Anesthesiology and Physical Medicine and Rehabilitation (Physiatry) practice what may be described as "Interventional Pain Management", so long as the physician has undergone rigorous training in or devotes a significant portion of his or her practice to the performance of interventional pain management procedures, typically under fluoroscopic guidance, and is familiar with the current medical literature regarding such techniques.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(g) (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician.

(4) "Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity".

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2). "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician

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assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

Followup:
6 Week(s)
Julia Fellows, PA-C

CC:
Kweller, Esq., Zachary : 01/26/2021
Castro, Mario : 01/26/2021

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 01/25/2021

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March 11, 2021

PANEL QUALIFIED MEDICAL RE-EVALUATION

RE: SHOCKLEY, Jonathan
DOB : 09/27/1978
CLAIM #: 7173815490
DOI: 0 2/15/2019
EMPLOYER: CardioNet, LLC

Dear Concerned Parties:

Mr. Jonathan Shockley had an appointment at the Remedy Medical Group at 490 Post Street, Suite 901, San Francisco, California from 11:30 a.m. to 12 noon. I spent a half-hour face to face with the patient. Doctus assisted me with five and a half hours of medical record review of 1,047 pages, many of which were duplicates and non-medical in nature. Two hours were spent in reviewing the relevant medical records. I spent one and a half hours drafting and editing this report. This will be billed as an ML101, with four hours spent.

I last saw Mr. Shockley on 01/23/20 for evaluation for his bilateral shoulder, arm, and hand pain. He had a cumulative trauma injury as a combination of peripheral nerve neuropathy of the cubital tunnel, carpal tunnel, and cervical radiculopathy.

Since I have last seen him, he tried gabapentin, but developed side effects and states that he feels he is persistently somnolent since that time. He also states he had some thyroid

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problems because of the gabapentin. He has been seen by Dr. Goren for peripheral decompressive surgery at the elbow and Dr. Slosar for a decompressive surgery of the C-spine. Both surgeons declined to operate on Mr. Shockley.

Mr. Shockley has been offered cervical epidural steroid injections, but he declines at this time.

He is interested in further acupuncture treatment which has been requested and denied.

His neck and arm pain have continued with some decrease in intensity.

The patient complains, in addition to pain in his upper extremities, of numbness in the ulnar aspect of his right and left forearm and numbness into his third, fourth, and fifth digits on the palmar and dorsal aspect that is intermittent.

CURRENT COMPLAINTS:

Currently, his bilateral arm pain is a VAS 4/10. It ranges from a VAS 2 to a VAS 7/10. His neck pain is a VAS 2/10. It ranges from a 2 to a 7/10.

His pain is aggravated by lifting, gripping, grasping, holding, and manipulating with his hands. It is made better with rest, anti-inflammatories, acupuncture, and neck traction.

He has no problems with sitting, standing, or walking. He is a right-handed.

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He endorses sleep disruption because of his pain and difficulty staying asleep and falling asleep. He can sleep six to seven hours a night. Previously, he slept seven to eight hours a night. His mood, he has increased anxiety and despair, but he feels that he is managing with medication.

He has had gastric GI tract upset with diclofenac.

His functional limitations include difficulty with writing, difficulty using a computer or cell phone, cooking, cleaning, lifting heavy objects, playing sports, sexual activity, and house repairs.

He currently is on modified work, but he has not worked since he was fired from his job at CardioNet.

MEDICAL HISTORY:

Unchanged.

SURGICAL HISTORY:

Unchanged.

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SOCIAL HISTORY:

He is single. He does not have any children. He does not consume any alcohol. He does not use any tobacco products.

FAMILY HISTORY:

1. Rheumatoid arthritis.

REVIEW OF SYSTEMS:

A fourteen-point review of systems is positive for continued dizziness, in addition to the aforementioned problems.

OCCUPATIONAL HISTORY:

There has been no change since I last saw him. He has been off work since June 2018.

CURRENT MEDICATIONS:

1. Diclofenac.
2. Voltaren.
3. Lidocaine cream.

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VALIDATED QUESTIONNAIRES:

1. PHQ-9 is 11/30 indicating mild reactive depression.
2. Epworth Sleepiness Scale is 4 indicating no abnormal daytime somnolence.

Please see the ADL worksheets for comprehensive review of ADL surveys.

MEDICAL RECORDS REVIEW:

06/05/19 Annie Ting, OT - Golden Gate Hand Therapy. Occupational Therapy Progress Note. CC: Patient states, "my worst pain is 6/10 and at the best it is always low level pain 1/10 and I always feel it. With doing daily activities, it causes low grade pain. I will be going to a 10-day meditation retreat at the end of the month, which will be nice for the hands. My right is worse but my left can definitely got to that level." Assessment/Plan: Patient presents with compromised circulation, which may be affecting healing process. He continues with poor activities tolerance and requires multiple rest breaks when completed strengthening exercises. He has minimal improvement at this point of therapy and may benefit from seeing alternative treatment options. OT was performed. F/u with MD appointment.

01/23/20 Adam J. Stoller, MD - Remedy Medical Group. Panel Qualified Medical Evaluation.

12/03/20 Thrisha Kashinath, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group. Supplemental Report. CC: Patient continues to report bilateral

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arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue, which he still feels is occurring. Due to the fatigue, he had some blood work done that showed elevated TSH. He attributes this elevation in TSH is due to his use of gabapentin and inquiries about having this level repeated. Discussion: This examiner reported to note that patient had excellent benefits from prior sessions of acupuncture. He reported a reduction in his pain complaints from a 4-5/10 to a 2-3/10 on VAS, constituting a 10-20% reduction in his pain complaints for 2-3 days. He was able to do his ADLs better and there was overall improvement in his symptoms with acupuncture therapy. This examiner requested to note that this patient did have a PQME with Dr. Stoller on 01/23/20. Dr. St oller did recommend that patient have acupuncture sessions under future medical care. This examiner kindly requested to reconsider authorization for 6 sessions of acupuncture for the neck, bilateral hands, wrists, and forearms. It is noted that patient meets the guidelines criteria for warranting treatment, and will continue to keep the insurance updated regarding this patient's progress. Further delay of this patient's treatment would only serve to prolong his suffering and increase the overall cost to the California Workers' Compensation system through prolongation of the utilization review process.

12/03/20 Adam J. Stoller, MD - Remedy Medical Group. Medical Legal Supplemental Report.

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12/10/20 Julia Fellows, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group. PTP's Progress Report. CC: Patient presents via Facetime to follow up on pain in his arm, bilateral hands and neck. He denies acute changes to his pain complaints on 12/10/17. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and he wanted to discuss the results with a specialist. However at the time, his insurance carrier was denying liability for his neck. He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID-19. These sessions expire in March 2021. Previously, he had been attending acupuncture therapy with benefit, but additional sessions have been denied and are currently being appealed. He has never trialed chiropractic therapy before, but he prefers to wait and see if acupuncture will be appeal approved prior to proceeding with chiro. He has also trialed massage therapy in the past although this actually aggravated his symptoms more. With regard to medication, he continues with lidocaine cream and Voltaren gel as topical medications. He denies side effects with his medications. He does request for refills on 12/10/20. He also inquires about trialing Flector patch for topical relief of his symptoms. He reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who informed him this would improve with time. Dx: 1) Cervical disc

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disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Prescribed Flector 1.3% patch. May consider trialing chiropractic therapy at his next visit should acupuncture remain denied. Recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim. With regard to his work restrictions, this examiner has indicated that he can perform one hour of computer work in an 8-hour day; unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. He states that he was recently let go from his employer. With regard to medications, Voltaren gel and lidocaine ointment refilled now. Will also trial him on Flector patch for topical relief. He has not trialed this yet; therefore, no previous benefit can be documented. Gabapentin discontinued due to side effects. As mentioned above, he has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving. Work Status: He is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to one hour in an 8-hour shift. Light computer work for up to an hour for an 8-hour shift. F/u in 4-6 weeks.

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PHYSICAL EXAM:

General:

Well-nourished, well-developed gentleman in no acute distress.

Cardiac:

His extremities are warm and well perfused.

Pulmonary:

He is breathing comfortably on room air.

HEENT:

He has 80 degrees of cervical rotation to the left and 60 degrees to the right with pain. He has 60 degrees of flexion and extension without pain. He has 40 degrees of lateral bend to the left and 40 degrees of lateral bend to the right. Lateral bend to the right is painful. He has positive facet loading signs on the right. He has tenderness to palpation over his right cervical paraspinal muscles.

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Musculoskeletal:

He has 5/5 biceps, triceps, and deltoid strength. His grip strength using a dynamometer on the right hand is 32 kg, 10 kg, and 14 kg, on the left side is 34 kg, 20 kg, and 32 kg. With biceps 10 cm above the olecranon process are 20 cm on the right and 26 cm on the left with his arms resting at side.

Neuro:

Sensation is intact to light touch in the bilateral upper extremities. He has positive Tinel's at the bilateral carpal tunnel and positive Tinel's at the bilateral cubital tunnel. Both of these Tinel's signs are more strongly positive on the right with increased paresthesia stimulation. Cranial nerves II through XII are intact.

Psych:

He has an odd affect. Regular speech tone and prosody. Logical thought process.

IMPRESSION:

This is a gentleman who suffers from a combination of cervical radiculopathy and ulnar and median mononeuropathies in his bilateral upper extremities.

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CAUSATION:

I find 100% causation to the workplace event of 02/15/19.

APPORTIONMENT:

He demonstrates some degenerative change of the cervical spine. 10% of his cervical injury will be apportioned to degenerative changes of the cervical spine. There is no apportionment for his entrapment of the bilateral ulnar nerves or bilateral median nerves.

PERMANENT AND STATIONARY STATUS:

The patient is permanent and stationary. He has declined further therapy. He develops reactions to most medications.

IMPAIRMENT:

Per page 392, table 15-5, he has a DRE Category II with an 18% Whole Person Impairment with a clinical history and examination findings compatible with a specific injury at the C5-C6 level with muscle guarding on the right side. He has symmetric range of motion of the cervical spine and complains of radicular pain without objective findings.

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For impairment of the ulnar nerve above the mid forearm, he reports changes in sensation occasionally in his upper arm and his lower arm and ulnar region, but he does not have reduced tactile sensibility with a 60% sensory impairment. 60% sensory impairment of the bilateral ulnar nerves is 4% Upper Extremity Impairment. At the median nerve at the wrist, he has occasionally distorted tactile sensibility that interferes with some activities that is at 40% which is a 15% Upper Extremity Impairment of the right median, across the median sensory and a 15% Upper Extremity Impairment on the left for a median nerve sensory deficit. As evidenced by reduced grip strength, he has a grade 4 motor deficit greater on the right side than the left side. On the right side, he has a 25% motor deficit which is a 3% Upper Extremity Impairment on the right. On the left, he has a 1% Upper Extremity Impairment. Totals for right upper extremity ulnar and median nerve impairment is 22% Upper Extremity Impairment on the right and 20% on the left. For the right side, a 22% Upper Extremity Impairment is equal to a 13% Whole Person Impairment and a 20% Upper Extremity Impairment is a 12% Whole Person Impairment.

Using the Combined Values Chart, 13% plus 12% is 18% plus 7% for the cervical impairment is a 20% Whole Person Impairment. I have considered Alvarez-Guzman and feel that the above strict interpretation is appropriate.

I have also considered additions for pain and I think that my rating of his DRE category involves pain and there is rating for pain in the sensory deficits in his ulnar and median nerves, so therefore no additional pain rating is appropriate.

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WORK RESTRICTIONS:

I am in agreement with Dr. Jamasbi's assessment of Mr. Shockley's work restrictions which are as follows: Repetitive activities with the upper extremities limited to one hour in an eight hour shift.

FUTURE MEDICAL CARE:

1. Mr. Shockley would be a candidate for a cervical epidural steroid injection.

2. Mr. Shockley would be a candidate for neuropathic pain medications.

3. Allowances should be made for nonspecific therapies such as TENS and acupuncture.

4. Mr. Shockley seems to have benefited from acupuncture and he would be a candidate for six sessions of acupuncture every six months as needed for flares of his pain.

Thank you very much for choosing me to be your QME. Should you have any questions or concerns, please do not hesitate to constitute them in the form of a request for supplemental and I would be happy to address them.

"I certify that I took the complete history from the patient, conducted the examination, reviewed all available medical records, and composed and drafted the conclusions of this

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Acupuncturist

Marina Zyskina, N.P.

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report. The conclusions and opinions within this report are solely mine. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. In accordance with Labor Code Section 5703(a) [2], there has not been a violation of Labor Code Section 139.3, and the contents of the report are true and correct to the best of my knowledge. I have not offered, delivered, received, or accepted any rebate, refunds, commission, preference, patronage, dividend, discount or other consideration for any referred examination or evaluation. This statement is made under penalty of perjury. Pursuant to 8 Cal. Code Regulations Section 49.2-49.9, I have complied with the requirement for face-to-face time with the patient in this evaluation. I have discussed apportionment in the body of this report. If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to a described disability represents my best medical judgment of the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664."

Sincerely,

Adam J. Stoller, M.D. 0311 28173771-28173784

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Attached: ADL worksheets

CC:

James Goines, Defense Attorney

Zachary Kweller, Applicant Attorney

Mario Castro, Claims Adjuster

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March 11, 2021

PANEL QUALIFIED MEDICAL RE-EVALUATION

RE: SHOCKLEY, Jonathan
DOB : 09/27/1978
CLAIM #: 7173815490
DOI: 0 2/15/2019
EMPLOYER: CardioNet, LLC

Dear Concerned Parties:

Mr. Jonathan Shockley had an appointment at the Remedy Medical Group at 490 Post Street, Suite 901, San Francisco, California from 11:30 a.m. to 12 noon. I spent a half-hour face to face with the patient. Doctus assisted me with five and a half hours of medical record review of 1,047 pages, many of which were duplicates and non-medical in nature. Two hours were spent in reviewing the relevant medical records. I spent one and a half hours drafting and editing this report. This will be billed as an ML101, with four hours spent.

I last saw Mr. Shockley on 01/23/20 for evaluation for his bilateral shoulder, arm, and hand pain. He had a cumulative trauma injury as a combination of peripheral nerve neuropathy of the cubital tunnel, carpal tunnel, and cervical radiculopathy.

Since I have last seen him, he tried gabapentin, but developed side effects and states that he feels he is persistently somnolent since that time. He also states he had some thyroid

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problems because of the gabapentin. He has been seen by Dr. Goren for peripheral decompressive surgery at the elbow and Dr. Slosar for a decompressive surgery of the C-spine. Both surgeons declined to operate on Mr. Shockley.

Mr. Shockley has been offered cervical epidural steroid injections, but he declines at this time.

He is interested in further acupuncture treatment which has been requested and denied.

His neck and arm pain have continued with some decrease in intensity.

The patient complains, in addition to pain in his upper extremities, of numbness in the ulnar aspect of his right and left forearm and numbness into his third, fourth, and fifth digits on the palmar and dorsal aspect that is intermittent.

CURRENT COMPLAINTS:

Currently, his bilateral arm pain is a VAS 4/10. It ranges from a VAS 2 to a VAS 7/10. His neck pain is a VAS 2/10. It ranges from a 2 to a 7/10.

His pain is aggravated by lifting, gripping, grasping, holding, and manipulating with his hands. It is made better with rest, anti-inflammatories, acupuncture, and neck traction.

He has no problems with sitting, standing, or walking. He is a right-handed.

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He endorses sleep disruption because of his pain and difficulty staying asleep and falling asleep. He can sleep six to seven hours a night. Previously, he slept seven to eight hours a night. His mood, he has increased anxiety and despair, but he feels that he is managing with medication.

He has had gastric GI tract upset with diclofenac.

His functional limitations include difficulty with writing, difficulty using a computer or cell phone, cooking, cleaning, lifting heavy objects, playing sports, sexual activity, and house repairs.

He currently is on modified work, but he has not worked since he was fired from his job at CardioNet.

MEDICAL HISTORY:

Unchanged.

SURGICAL HISTORY:

Unchanged.

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SOCIAL HISTORY:

He is single. He does not have any children. He does not consume any alcohol. He does not use any tobacco products.

FAMILY HISTORY:

1. Rheumatoid arthritis.

REVIEW OF SYSTEMS:

A fourteen-point review of systems is positive for continued dizziness, in addition to the aforementioned problems.

OCCUPATIONAL HISTORY:

There has been no change since I last saw him. He has been off work since June 2018.

CURRENT MEDICATIONS:

1. Diclofenac.
2. Voltaren.
3. Lidocaine cream.

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VALIDATED QUESTIONNAIRES:

1. PHQ-9 is 11/30 indicating mild reactive depression.
2. Epworth Sleepiness Scale is 4 indicating no abnormal daytime somnolence.

Please see the ADL worksheets for comprehensive review of ADL surveys.

MEDICAL RECORDS REVIEW:

06/05/19 Annie Ting, OT - Golden Gate Hand Therapy. Occupational Therapy Progress Note. CC: Patient states, "my worst pain is 6/10 and at the best it is always low level pain 1/10 and I always feel it. With doing daily activities, it causes low grade pain. I will be going to a 10-day meditation retreat at the end of the month, which will be nice for the hands. My right is worse but my left can definitely got to that level." Assessment/Plan: Patient presents with compromised circulation, which may be affecting healing process. He continues with poor activities tolerance and requires multiple rest breaks when completed strengthening exercises. He has minimal improvement at this point of therapy and may benefit from seeing alternative treatment options. OT was performed. F/u with MD appointment.

01/23/20 Adam J. Stoller, MD - Remedy Medical Group. Panel Qualified Medical Evaluation.

12/03/20 Thrisha Kashinath, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group. Supplemental Report. CC: Patient continues to report bilateral

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arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue, which he still feels is occurring. Due to the fatigue, he had some blood work done that showed elevated TSH. He attributes this elevation in TSH is due to his use of gabapentin and inquiries about having this level repeated. Discussion: This examiner reported to note that patient had excellent benefits from prior sessions of acupuncture. He reported a reduction in his pain complaints from a 4-5/10 to a 2-3/10 on VAS, constituting a 10-20% reduction in his pain complaints for 2-3 days. He was able to do his ADLs better and there was overall improvement in his symptoms with acupuncture therapy. This examiner requested to note that this patient did have a PQME with Dr. Stoller on 01/23/20. Dr. St oller did recommend that patient have acupuncture sessions under future medical care. This examiner kindly requested to reconsider authorization for 6 sessions of acupuncture for the neck, bilateral hands, wrists, and forearms. It is noted that patient meets the guidelines criteria for warranting treatment, and will continue to keep the insurance updated regarding this patient's progress. Further delay of this patient's treatment would only serve to prolong his suffering and increase the overall cost to the California Workers' Compensation system through prolongation of the utilization review process.

12/03/20 Adam J. Stoller, MD - Remedy Medical Group. Medical Legal Supplemental Report.

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12/10/20 Julia Fellows, PA-C/Babak Jamasbi, MD - Pain and Rehabilitative Consultants Medical Group. PTP's Progress Report. CC: Patient presents via Facetime to follow up on pain in his arm, bilateral hands and neck. He denies acute changes to his pain complaints on 12/10/17. He continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment. He also reports pain in his neck that radiates down into his bilateral upper extremities. He did undergo a MRI of the neck and he wanted to discuss the results with a specialist. However at the time, his insurance carrier was denying liability for his neck. He has been approved for 6 sessions of aqua therapy but these are currently on hold as no pool facility is open due to COVID-19. These sessions expire in March 2021. Previously, he had been attending acupuncture therapy with benefit, but additional sessions have been denied and are currently being appealed. He has never trialed chiropractic therapy before, but he prefers to wait and see if acupuncture will be appeal approved prior to proceeding with chiro. He has also trialed massage therapy in the past although this actually aggravated his symptoms more. With regard to medication, he continues with lidocaine cream and Voltaren gel as topical medications. He denies side effects with his medications. He does request for refills on 12/10/20. He also inquires about trialing Flector patch for topical relief of his symptoms. He reports that a few months back he took gabapentin briefly to see if it would improve his upper extremity pain. However, this caused extreme fatigue which he still feels is occurring. He states he met with a neurologist through his private insurance who informed him this would improve with time. Dx: 1) Cervical disc

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disorder with radiculopathy, unspecified cervical region. 2) Other soft tissue disorders related to use, overuse and pressure, right upper arm. 3) Other soft tissue disorders related to use, overuse and pressure, left upper arm. 4) Other soft tissue disorders related to use, overuse and pressure, right forearm. 5) Lesion of ulnar nerve, unspecified upper limb. Tx Plan: Prescribed Flector 1.3% patch. May consider trialing chiropractic therapy at his next visit should acupuncture remain denied. Recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim. With regard to his work restrictions, this examiner has indicated that he can perform one hour of computer work in an 8-hour day; unable to determine how long these work restrictions are going to be in effect, this largely depends on how he continues to respond to treatment and if he receives adequate treatment for his cervical spine, which is currently being disputed as a covered body part despite having an MRI of the cervical spine authorized. He states that he was recently let go from his employer. With regard to medications, Voltaren gel and lidocaine ointment refilled now. Will also trial him on Flector patch for topical relief. He has not trialed this yet; therefore, no previous benefit can be documented. Gabapentin discontinued due to side effects. As mentioned above, he has been having considerable fatigue after trialing gabapentin for a short amount of time. He apparently had an abnormal TSH shortly after discontinuing gabapentin and he believes that the medication is responsible for the abnormal level. Since patient took such a low dose for such a short amount of time, it is hard to say if gabapentin truly did cause the TSH level abnormality. He does feel that the fatigue is improving. Work Status: He is not Permanent and Stationary. Restrictions: Repetitive activities using upper extremities limited to one hour in an 8-hour shift. Light computer work for up to an hour for an 8-hour shift. F/u in 4-6 weeks.

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PHYSICAL EXAM:

General:

Well-nourished, well-developed gentleman in no acute distress.

Cardiac:

His extremities are warm and well perfused.

Pulmonary:

He is breathing comfortably on room air.

HEENT:

He has 80 degrees of cervical rotation to the left and 60 degrees to the right with pain. He has 60 degrees of flexion and extension without pain. He has 40 degrees of lateral bend to the left and 40 degrees of lateral bend to the right. Lateral bend to the right is painful. He has positive facet loading signs on the right. He has tenderness to palpation over his right cervical paraspinal muscles.

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Musculoskeletal:

He has 5/5 biceps, triceps, and deltoid strength. His grip strength using a dynamometer on the right hand is 32 kg, 10 kg, and 14 kg, on the left side is 34 kg, 20 kg, and 32 kg. With biceps 10 cm above the olecranon process are 20 cm on the right and 26 cm on the left with his arms resting at side.

Neuro:

Sensation is intact to light touch in the bilateral upper extremities. He has positive Tinel's at the bilateral carpal tunnel and positive Tinel's at the bilateral cubital tunnel. Both of these Tinel's signs are more strongly positive on the right with increased paresthesia stimulation. Cranial nerves II through XII are intact.

Psych:

He has an odd affect. Regular speech tone and prosody. Logical thought process.

IMPRESSION:

This is a gentleman who suffers from a combination of cervical radiculopathy and ulnar and median mononeuropathies in his bilateral upper extremities.

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CAUSATION:

I find 100% causation to the workplace event of 02/15/19.

APPORTIONMENT:

He demonstrates some degenerative change of the cervical spine. 10% of his cervical injury will be apportioned to degenerative changes of the cervical spine. There is no apportionment for his entrapment of the bilateral ulnar nerves or bilateral median nerves.

PERMANENT AND STATIONARY STATUS:

The patient is permanent and stationary. He has declined further therapy. He develops reactions to most medications.

IMPAIRMENT:

Per page 392, table 15-5, he has a DRE Category II with an 18% Whole Person Impairment with a clinical history and examination findings compatible with a specific injury at the C5-C6 level with muscle guarding on the right side. He has symmetric range of motion of the cervical spine and complains of radicular pain without objective findings.

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For impairment of the ulnar nerve above the mid forearm, he reports changes in sensation occasionally in his upper arm and his lower arm and ulnar region, but he does not have reduced tactile sensibility with a 60% sensory impairment. 60% sensory impairment of the bilateral ulnar nerves is 4% Upper Extremity Impairment. At the median nerve at the wrist, he has occasionally distorted tactile sensibility that interferes with some activities that is at 40% which is a 15% Upper Extremity Impairment of the right median, across the median sensory and a 15% Upper Extremity Impairment on the left for a median nerve sensory deficit. As evidenced by reduced grip strength, he has a grade 4 motor deficit greater on the right side than the left side. On the right side, he has a 25% motor deficit which is a 3% Upper Extremity Impairment on the right. On the left, he has a 1% Upper Extremity Impairment. Totals for right upper extremity ulnar and median nerve impairment is 22% Upper Extremity Impairment on the right and 20% on the left. For the right side, a 22% Upper Extremity Impairment is equal to a 13% Whole Person Impairment and a 20% Upper Extremity Impairment is a 12% Whole Person Impairment.

Using the Combined Values Chart, 13% plus 12% is 18% plus 7% for the cervical impairment is a 20% Whole Person Impairment. I have considered Alvarez-Guzman and feel that the above strict interpretation is appropriate.

I have also considered additions for pain and I think that my rating of his DRE category involves pain and there is rating for pain in the sensory deficits in his ulnar and median nerves, so therefore no additional pain rating is appropriate.

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WORK RESTRICTIONS:

I am in agreement with Dr. Jamasbi's assessment of Mr. Shockley's work restrictions which are as follows: Repetitive activities with the upper extremities limited to one hour in an eight hour shift.

FUTURE MEDICAL CARE:

1. Mr. Shockley would be a candidate for a cervical epidural steroid injection.

2. Mr. Shockley would be a candidate for neuropathic pain medications.

3. Allowances should be made for nonspecific therapies such as TENS and acupuncture.

4. Mr. Shockley seems to have benefited from acupuncture and he would be a candidate for six sessions of acupuncture every six months as needed for flares of his pain.

Thank you very much for choosing me to be your QME. Should you have any questions or concerns, please do not hesitate to constitute them in the form of a request for supplemental and I would be happy to address them.

"I certify that I took the complete history from the patient, conducted the examination, reviewed all available medical records, and composed and drafted the conclusions of this

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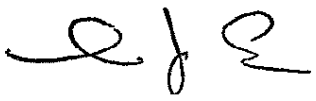

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Attached: ADL worksheets

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